Maryland
STATE MEDICAL JOURNAL
Medical and Chirurgical Faculty of the State of Maryland

VOLUME 7 *December, 1958* NUMBER 12

Geriatrics Issue

INTRODUCTION

HERMAN SEIDEL, M.D.

The Committees on Geriatrics of the Medical and Chirurgical Faculty of the State of Maryland and of the Baltimore City Medical Society are sincerely grateful for the courtesy extended to them for a second time by the editor of the Maryland State Medical Journal, Dr. George H. Yeager, to dedicate an issue to Geriatrics.

In this issue, we are fortunate in having as the leading article a paper read by Dr. Robert T. Monroe at the Spring session of the Medical and Chirurgical Faculty. This article gives a clear and comprehensive statement on the development of Geriatrics and mention is made of the problems arising in the wake of this phenomenon.

An article by Dr. James A. McCallum discusses some of the problems of the chronically ill and the facilities which the State of Maryland has provided for their relief, as well as the rehabilitation work and the measure of success attained.

There appears in this issue the first installment of a survey undertaken by the Baltimore Health Department, the Mayor's Commission for the Problems of the Aged in Baltimore, and the joint Committees on Geriatrics. This installment reports on the results of the survey of private nursing and convalescent homes. The significance of the findings are discussed by Dr. Matthew L. Tayback, statistician for the Baltimore Health Department, by Mr. Herbert Fritz, State Department of Health, and by Mr. Joseph Conte who carried out the survey.

The project, when complete, will include a survey of public institutions for the housing of the aged in Baltimore and vicinity and a survey of medical facilities for the aged in the outpatient clinics and hospitals in the urban area.

To complete this issue dedicated to Geriatrics, we have compiled "Geriatrics—Briefs and Abstracts", which offers useful information and reflects, in a small measure, the activities in current Geriatric literature.

The Committees on Geriatrics have undertaken a project to organize in Maryland a branch of the American Gerontologic Society.

Developments in the field of Geriatrics are proceeding at a fairly rapid rate and with accelerated momentum. Not quite two years ago the

American Medical Association appointed a National Committee on Geriatrics. This committee is steadily enlarging its program and also activating many committees and groups all over the United States. It seems, from all indications, that some form of national body will crystallize.

The American Gerontologic Society seems to be the organization that is meeting the expectations of a national organization to develop clinical research and allied activities in the field of Geriatrics. It is more than likely that the future American Gerontologic-Geriatric Society will assume a form somewhere between the American Pediatric Society and the American Heart Association. Establishment of a branch of the American Gerontologic Society will serve as the vanguard for the development of the broader organization.

2404 Eutaw Place
Baltimore 17, Maryland

Committee on Geriatrics of the Medical and Chirurgical Faculty of the State of Maryland	*Committee on Geriatrics of the Baltimore City Medical Society*
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W. Alfred Van Ormer, M.D.	

Scientific Paper

SOME OUTSTANDING PROBLEMS OF HEALTH IN OLD AGE[1]

ROBERT T. MONROE, M.D.[2]

Any discussion of the health problems of old people that is intended to reach toward a better understanding by those who are really interested must start with recognition of the fact that the terms are saturated with prejudice and sentimental overtones. Who are the old people? Different answers will always be given by teenagers, young adults, and by people in their fifties, sixties and even seventies. Changing the label to "the elderly," "the aged," or "senior citizens" merely brings out more charmingly repellent associations. All of us are aging every day, and I can do no better than to conclude that old people are those judged to be so on a given scale of values.

What is health? It is not merely the absence of disease, for we speak of various types of health: physical health, mental health, social health, and so on. Nor are we satisfied to say that it is just the absence of disturbance in any or all areas of life; we sense that more positive goods are to be included before we agree that we are talking about the same thing.

The agents which invade health have received most attention, yet descriptions of health and old age based on their enemies are both unrealistic and threatening. One class of writers, concerned with the losses suffered by old people, regards old age as resignation from active life, well earned and worthy of rewards, preferably in tangible forms. Another class of writers, chiefly the medical profession, views old age as a period of bodily deterioration, variable in amount and in rate of progression, but inevitable and inescapable.

It is well to look at the whole spectrum of facts if we wish to avoid getting stuck on either the blue side or the rosy one. It is true that for many years there has been an increase in admissions of aging patients to mental institutions. The great majority of patients in nursing and convalescent homes are elderly. The proportion of beds in general hospitals which are used by patients over the age of 60 has grown greatly. The average duration of hospital stay is much greater for old people than for younger ones. But it is also true that less than five per cent of all people over the age of 65 are in institutions of any sort, including mental hospitals, chronic disease hospitals, nursing homes, and public and private old age homes. And at least 75 per cent of people over the age of 65 consider themselves to be essentially healthy most of the time.

Autopsy studies of old people show many more states of disease than were known in life, by either the victims or their physicians, and they show other tissue aberrations whose significance is not as yet understood. It is not clear that the revealed diseases are continuously cumulative after age 65, although the tissue aberrations may be; but the diseases are much more numerous than they are in autopsied middle-aged patients. We cannot know, of course, how much suffering, if any, these diseases caused in life, or whether their manifestations failed to be recognized or were withheld from inspection by the medical profession. We can only speculate that some individuals may have a curious ability to make peaceful adjustments to many diseases without outside assistance, or that we may be wrong in supposing that every disease must manifest its peculiar symptoms sooner or later.

Those responsible for the medical care of

[1] Presented at the One Hundred Sixtieth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland on April 18, 1958.

[2] Clinical Associate in Medicine, Harvard Medical School and Peter Bent Brigham Hospital; Chief, Division of Health and Personality, The Age Center of New England, Inc., Boston, Massachusetts.

aging people are impressed by the discrepancy that so often exists between the many things that are wrong with them and the satisfactory equilibria that they apparently enjoy. They have various allergies that might be activated; there are diseases which were once active that might become active again; there are others that are potentially harmful. There are threats in heart murmurs and hypertension and poor peripheral arterial pulsations. There are laboratory threats in an elevated blood sugar or cholesterol, or in electrocardiographic tracings or on X-ray films. Do we disregard them and attend strictly to their current troubles? Do we scold them and worry them by telling them the "whole truth," a good bit of which we know may never happen and we are not sure of anyway? Some of us learn to keep them in mind when crises arise and in the meantime take advantage of every opportunity to foster improvements and the understanding cooperation of the patients.

If we define health as what is normal, we shall find that we have sharpened the definition surprisingly little. For each of us is absolutely unique. There never was, is not now, and never will be another human being precisely like myself. When one considers the various combinations formed by chromosomes; when one recalls the hazards of life in utero, in passage through the birth canal and in the first few months and years in the external world; when one notes the wide variations that are accepted as normal for the size and weight of each organ and also for its blood supply and innervation; when the wide range of values regarded as normal for the cellular elements of the blood, for the chemical and hormonal and enzymatic elements of the blood and tissues are remembered; and when one perceives the variety of transient or lasting restructuring that goes on every day and every year of life in the interaction of the individual with his particular environment, then we can understand the somatic basis for the concept of democracy, western civilization style. The uniqueness of the personality (based on the soma and some nine billion cells in the central nervous system, organized from simple intake-output responses to more complex association systems every day of life) is also self evident. Each perception is received by a unique system, stored in his particular dynamic equilibrium of somatic psychological association systems, and alters every following perception and equilibrium.

The impact of environment is not all one-sided, for by his goals, drives and motivations the individual affects people and things about him. For good or ill he shares his every experience with others. The troubles which he conceals from others and those of which he is unaware nevertheless affect his drives and attitudes and energies. Every disease, therefore, can be said to be a matter of public health, or, as John Donne wrote, "No man is an Iland intire unto himself." But, since each man, consciously and unconsciously, is aware of his uniqueness, how each event affects his particular setup and when and how it seems safe for him to respond to it, every disease must also be regarded as a matter of private health. It is equally true that every man is an island entire unto himself. The value of the individual is central to the world's great religions and philosophies. His worthiness is in his hands, and in our judgment.

These facts apply with particular force to old people. They are more than ever the individuals they always have been, with their increasingly unique biological, sociological and spiritual values. They continue to be developing, adjusting, interacting, future-oriented people. They are more complicated and more intricately organized than younger people, although the quality of their interplay is somewhat altered by long custom and by attitudes. But, our society being what it is, there are a thousand who shout, "those old crocks" to the one who whispers, "it is nice that the young have beauty,—they have so little else to recommend them."

Health, then, appears to be a judgment based on many scales of normal standards and rendered by an individual that he—or someone else—is adjusting satisfactorily on the whole to the internal and external circumstances in which he is operating. It is a constantly changing evaluation. It is influenced by the weight assigned to events perhaps fully as much as by the events themselves, so that one may be

thought both healthy and sick at the same time, as with an ordinary cold. On its positive side it is called fitness,—a label that may be highly specific for one skill or sport or just a general sense of well-being, something more than the saying that health is what you don't know you have until you have lost it.

We have at our disposal a rich and valid body of data on how the normal healthy infant and child grow, physically, intellectually, emotionally. We know a great deal about the adolescent boy and girl. But from there on our data become increasingly scarce and spotty. We have many figures on particular population samples, such as draft board examinations, insurance and industrial medicine studies, but we must do a lot of guessing about the total health standing of young and middle aged people. Almost all our data on old people are derived from studies on those in institutions and on those who have suffered other than physical defeats,—and yet, as pointed out above, the great majority of old people are not in institutions and consider themselves to be healthy.

Is this a reflection of the American culture's interest in only the new models? It is more likely an escape from authority. Infants are dominated completely by parents and pediatricians. Children are dominated in constantly decreasing degrees by them and by teachers. When school is over, children become adults who recognize no superiors. They take their guidance from their families, their peers, and the cues to which they are sensitive in our culture; and they build up defenses of many sorts to insure their freedom of choice in action. These defenses are alerted when some authority attempts to perform physical or psychological tests upon them or to make surveys of them. In their old age the defenses are well established but the usual guide-lines to the community are frayed.

Our status as physicians is necessarily authoritarian and we must realize how it can distort our observations and our interactions with lay people. We are hired to correct evils. We intend to do good. To find the answers which are demanded of us we may have to invade cherished privacies. Our studies and advice may upset present programs and future goals. One aspect of the art of medicine is in sensing when one must take charge and when one should not, in knowing and respecting the standards by which the patient lives. More important than our solution of a present trouble is the example of tolerant equality which we live every day, on or off duty. The data on which we form our judgments will be colored according to whether we deal with our old patients with disgust or amazement, with affectionate superiority or with equal and dispassionate regard.

In our hospitals, all the workers are ancillary to us and share our cloak of authority. Here much greater distortions of lay personalities are produced. They are due not merely to the disturbances in their bodies which necessitated institutional care but more importantly to the conduct of the workers and the pressures of strange activities. Studies of the psychological, sociological and other personality aspects of elderly hospitalized patients can be accepted only to the degree that they acknowledge these facts. This applies particularly to our teaching and research hospitals. It might be interesting to observe the difference in atmosphere and status of the patients in private and simple community hospitals where studies are not done.

The Age Center of New England was established three years ago to reach toward solutions of these problems. It was designed as a new agency in a neutral setting in such a way as to attract the cooperation of aging, independent, apparently healthy people—the majority which we have dimly seen in all statistics. Interviews and tests that describe the members precisely in each area of their past lives and present situations are given—some thirty of them at the average of one hour each week according to their convenience. Physical health is assayed by what the members say they have suffered, what diseases they (and their doctors if they have them) say they have or have had, what their physical output and their nutrition are. More exact studies of the quality of sensory input are being designed for eyes, ears, taste, touch, smell; and neurological and musculoskeletal studies to describe how well they move in

their environment are on order. Psychological health is assayed by a number of tests of intelligence, attitudes, personality and perception. Sociological and human relations instruments describe in detail their associations with family, friends and community, and their activity in their life work and in their avocations and recreations. Each instrument is validated before use by experts in its field and by the research advisory committee of the Center.

I, who have yearned for such an agency for many years, am constantly amazed at three things: the number and quality of the men and women who voluntarily submit to all these tests (and once they start, the majority do all that we ask and even look for more); the caliber of the specialists and interviewers who are eager to participate in the studies; and the cooperation of the business and industrial community and of responsible foundations, both private and governmental, in providing adequate financial support.

It will take a good deal of time to interpret our data. We think that they will describe what normal old age is and that they will reveal some of the reasons why it is achieved. We believe, too, that our methods of study have constituted a self-guided review of assets and stresses which has been of real value to our members. Right now I can give you only my personal impressions of the group. There are over 600 of them, a few more men than women. The age range is from 46 to 93 years, with the great majority between 60 and 75 years.

Physical health clearly does not require the absence of disease now or in the past. Only a small percentage of our members (possibly 10 per cent) have suffered no operation, no fracture, no serious accident, no stay in bed, and have no observed clinical disease now. Some have experienced a variety of symptoms during much of their lives although their physicians report them free of significant disease. Some who have identified diseases are curiously little disturbed by them. Many of them have paid little attention in recent years to physical exercise and began long ago to abandon the games and play of their youth, though this seemed to vary with their childhood opportunities and the customs of their circle of friends. Some, however, get real pleasure out of long walks or exercises for fitness, and almost no member ever uses the elevator to reach the Age Center rooms on the second floor. Weather is perhaps as common a subject of conversation with them as with others, but they do not find it so bad or prohibitive, winter or summer. They can be counted on to keep their appointments as regularly as the staff. Their ideas about food do not seem as violently held as by others; they seem to eat by habit or with enjoyment rather than to choose consciously what is good for them.

All old people seem to fear that they are losing their memory, and our Age Center group is no exception. The facts are hard to get at. True memory loss is a feature of organic brain damage, as in cerebral arteriosclerosis with psychosis and in senile dementia; but these together probably do not make more than 10 per cent of our aging population. Some loss of recall at any age may be due to a lack of sensory input; this may account for the inferior performance of some who have lost sight or sound or ambulation. Capacity to recall at any given time also depends on the keenness of attention, on physical alertness and confidence, and on drive and motivation. Memory is often blocked by thinking more of not being able to recall than of the fact to be recollected. Finally, it is well to understand that memories become ever more complex and embellished with age. An image calls to mind many others like it and many incidents related to those images. The selection of one desired fact from among all these highways and byways requires discipline and tends to slow up performance.

Our work at the Age Center has not progressed far enough for us to be sure of any predictions or to give advice with confidence. The following beliefs are, therefore, my own, possibly too strongly influenced by my training in clinical medicine.

Health in old age requires, first of all, command of the body. To avoid or control diseases,

it is desirable to have a physician (or clinic) in whom one has confidence. Up-to-date mutual acquaintance with him improves the chances of lessening both present troubles and fears of future ones. A healthy state of the bones and muscles and joints requires regular use. Respiration, circulation, digestion, nutrition improve with exercise also. Not all the exercise should be work, for this can be done awkwardly and with strain; physical play and response to music promote coordination, confidence and zest. The vigorous old person is not limited in his program by effort or ordinary hazards, including weather, nor does he spend much time worrying over whether it is proper at his age to play a full part in life.

Health in old age requires, secondly, command of the personality. This includes making the best of what one has, disciplining one's self to pay strict attention to present duties and to the pursuit of realistic goals, discovering alternative paths when one is blocked. It includes exercise of the social muscles, improving family ties, repairing and replacing friendships, using the tolerance of years of acquired wisdom to foster adjustments in one's self and community. It includes defense of the precious freedom to make one's own choices of living and acting. It recognizes that one is still becoming, just as one always has been.

270 Commonwealth Avenue,
Boston 16, Massachusetts

The following books have been helpful in the preparation of this paper.

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LABORATORY FACILITIES FOR OUT-PATIENTS

That physicians of Maryland are unaware of the availability of medical laboratory facilities for out-patients, supervised by practicing pathologists, was apparent at the semi-annual meeting of the Medical and Chirurgical Faculty in Ocean City. In the discussion of the resolution to limit the activities of the State Board of Health Laboratories to fields of Public Health and indigent care, it was brought out that adequate private laboratories, capable of handling the volume and variety of clinical laboratory tests required, are distributed throughout the state.

A recent survey made by the Maryland Society of Pathologists among its membership revealed that currently unused facilities in private and hospital laboratories supervised by qualified pathologists, to do the following numbers of clinical laboratory determinations on out-patients; are available in Maryland:

Western Maryland-Hagerstown-Cumberland area	1500 per month
Eastern Shore area	1000 per month
Central Maryland-Baltimore area	7300 per month
Southern Maryland (including Bethesda, Silver Spring, etc.)	3000 per month
Total	12,800 per month

This is exclusive of cytologic tests for the diagnosis of cancer.

ARTICLES OF GERIATRIC INTEREST

THE MARYLAND STATE CHRONIC DISEASE HOSPITALS

ORLYN H. WOOD, M.D.,* DAVID H. HOLLANDER, M.D.,† AND J. A. McCALLUM, M.D.‡

On March 18, 1943, the Maryland State Legislature approved a bill establishing chronic disease hospitals in Maryland (1). This discussion is a recapitulation of the origin, development, and present status of the chronic hospital movement.

Background—The Almshouses

The chronic hospitals today have a function in caring for the indigent chronically ill that, prior to 1943, was chiefly provided by county almshouses. These hospitals were necessary because medical care in the almshouse was inadequate. It is curious to note that in 1754, when almshouses were first proposed, the principal argument advanced was that medical care would be improved. The colonial governor, Horatio Sharpe, wrote May 11, 1754, to London to Cecilius Calvert, secretary for Maryland to the Sixth Lord Baltimore: "... concerning the present manner of supporting the Poor I would recommend to them the building work-houses in every County for the Reception of Vagrants & such as apply for Relief which would in good measure oblige them to labour for their maintenance & part of such Work house might be appropriated to the Reception of the County Invaleeds & patients who would thereby receive the Benefit of the County Phisitian's Attendance & Care for which He has a valuable Consideration yearly but on account of His Patients being so much dispersed as they are at present can possibly do them very little Service" (2).

Calvert replied in a long letter dated December 10, 1754: "Of County Work Houses you Note for Vagrants. My Lord Approves well of such a Law ..." (2). Many of the counties thereafter requested almshouses and authorizing laws were passed by the General Assembly, the earliest in 1768.

Although Governor Sharpe intended the almshouses to care for the needs of the poor, these institutions over the next hundred years came to be in most instances places where sanitary conditions were incredible and medical care almost non-existent.

Almhouse Studies

In 1877 Dr. C. W. Chancellor (3), directed by Governor John Lee Carroll to report on the condition of the state prisons, almshouses and public hospitals, wrote:

"It is painful to report the shocking condition in which many of the public institutions were found and it is difficult to conceive that anything worse ever existed in a civilized country" (3).

In summarizing the conditions which he described in the almshouses he quoted Reil's picture of German asylums in 1803:

"They are neither curative institutions nor such asylums for the incurable as humanity can tolerate. They are for the most part veritable dens, deficient in ventilation, in the facilities for recreation, in short they are wanting in all the physical and moral means necessary to the care and comfort of the inmates."

During the next fifty years some of the abuses of the system were lessened, and other facilities became available for special groups. Institutional care of the insane, in particular, was a subject of public interest and many of these individuals were removed from the almshouses.

In the 1920's a number of private citizens who became interested in the almshouse abuses

* Chief Physician, Montebello State Hospital.
† Pathologist, Chronic Disease Hospitals.
‡ Superintendent, Chronic Disease Hospitals.

urged that they be abolished. A prominent Baltimore physician, Dr. George Walker, personally financed a study of the almshouses (4). In 1931 Governor Ritchie appointed official commissions to investigate prevailing conditions.

The Ritchie Commission of 1931 (5) noted that since vagrants, children, and the insane no longer had to be cared for in almshouses, the problem resolved itself into the care of the aged poor, and the sick and infirm.

The report of this Commission stated: "... the need for a change from the present system of county poor farms is beyond question. Maryland cannot assume a responsibility of continuing a system which leaves to dirt and disease, misery, and fire hazard, helpless wards of the state" (5).

The commission recommended that the county almshouses be replaced by two institutions, one on the Eastern Shore and one on the Western Shore.

Although no legislative action resulted from the 1931 report, the need for change was widely recognized, and was reaffirmed by an official commission in 1933.

In 1940 under Governor O'Conor a detailed study was made by the Research Division of the Maryland Legislative Council. Their summarized data showed that roughly one sixth of the inmates could have been cared for outside of institutions, another sixth required mental hospital care, while the major group, roughly two-thirds, were in need of chronic hospital care.

The Almshouse Commission (6) of 1940, under the chairmanship of Walter N. Kirkman, had been carefully chosen by Governor O'Conor to include representative groups from labor, welfare, medicine and the legislature. They recommended that Maryland erect chronic hospitals for the medical care of the indigent.

Legislative Action

The Legislature of 1943 (1), on the basis of the 1940 Almshouse Commission report, authorized the construction of two chronic hospitals "for needy persons who require medical, nursing or custodial care by reason of chronic illness or infirmity." Two sites were to be selected by the State Board of Health, one on the Eastern Shore, and one on the Western Shore. They were to be in urban areas where sewerage and water supplies were already available and where there were already the facilities of an accredited hospital.

The Legislature of 1945 (1) acted favorably on the desire of Baltimore City to be included in the plan and authorized a third hospital in Baltimore.

The Legislature of 1957 (1) revised the law which now reads: [Chronic hospitals are] . . ."for persons . . . who require constant medical and nursing care provided by a hospital by reason of chronic illness or infirmity, or who are suffering from a chronic disability amenable to rehabilitation." The law specifically excludes from the program patients with active tuberculosis or chronic mental disease.

Rehabilitation

With the development of the chronic disease hospital program, rehabilitation has become an increasingly important goal. This concept was clearly set forth in the 1940 Almshouse Commission (6) report:

> "The commission . . . . wishes to stress the point of view that *incurability* should not be a criterion for admission to the chronic hospital. Many of the cases which will be admitted will no doubt be incurable, but many cases requiring treatment for many months, or for a year or more, will be admitted where there is possibility of partial or complete rehabilitation by chronic hospital care" (6).

Unfortunately, because this was not included in the original enabling legislation, Deer's Head, the first institution built under the program, was not provided with facilities for physical medicine. The oversight has since been remedied in part, and Physical Medicine and Rehabilitation Departments have been prominent features in subsequent construction.

The aim of rehabilitation is to assist the disabled in becoming as independent as possible. For some this means recovery to the point of completely independent self care and perhaps even a return to gainful employment; others who

acquire a high degree of independency in self care can be returned to their homes since they no longer require nursing care; while others, less fortunate, may never acquire a significant degree of independent self care, but can be taught many activities which simplify their care and lead to a more satisfactory life outside a hospital.

The principle of rehabilitation was clearly stated in the joint report of the chairmen of the Senate Finance Committee and the House Ways and Means Committee of the 1957 Legislature:

> "In approving these expenditures it is the hope of the committees that a constructive and economical service will be promoted by the intensification of the *curative* and *rehabilitative* aspect of the state chronic disease program" (7).

Deer's Head Hospital

In 1946, following the delay caused by World War II, plans were ready for a hospital in Salisbury. However, bids and re-bids were in excess of the original estimate of 1943 and the eventual cost of this one hospital approximated the appropriation intended for two hospitals. Deer's Head Hospital was finally constructed and placed in operation in October 1950. It takes its name from the small peninsula on which it is located. The capacity is 284 beds and occupancy now varies from 90 to 96 per cent.

Montebello Hospital

In 1952, Sydenham, Baltimore City's former contagious disease hospital, was purchased from the City by the State. Operation was started in the existing buildings in April 1953 when a number of patients were transferred from the temporary Ritchie State Hospital at Cascade, Maryland. The name was changed to Montebello, taken from the name of the nearby lake and filtration plant. Two additions have been constructed, one of 213 beds now completed, and another of 180 beds under contract and to be completed in 1958. The total bed capacity will soon be 482.

Western Maryland Hospital

This 298 bed facility located just within the northern city limits of Hagerstown on the grounds of the former Washington County Almshouse was completed and occupied in November 1957. Dr. Murray Ferderber of the University of Pittsburgh emphasized rehabilitation in his keynote address at the dedication when he stated: "Today it is over the hill to restoration, and then back home—a two-way ticket instead of a one-way ride."(4)

Organization

The three hospitals are under the single direction of a Superintendent, a Medical Director, and a Director of Physical Medicine. They have responsibility for carrying out the policies of the State Board of Health in respect to type and scope of services rendered and qualifications and status for admission and discharge. Montebello Hospital in Baltimore, the largest and most centrally located, serves as headquarters for the supervisory group. The Medical Director and the Director of Physical Medicine spend two days each week at one of the other hospitals for group evaluation of new patients and in directing medical and rehabilitation care in these hospitals.

The Medical Director is responsible for the organization and direction of the medical staffs and services. Each of the three hospitals has a Chief Physician responsible for the direction of staff physicians, nursing, clinical laboratory, X-ray, and pharmacy service in his hospital.

The Director of Physical Medicine and Rehabilitation is responsible for the organization and direction of a department of Physical Medicine in each of the three hospitals. Personnel of these departments consist largely of physical therapists, occupational therapists and aides.

Admissions

Admission to the chronic hospitals is made on the basis of a statement by a physician who, after an examination, finds that the patient is in need of chronic hospital care, and after review

and approval of the application by the chronic hospital admissions committee. The applicant may express preference for a specific hospital or, if immediate hospitalization is necessary, he may be admitted to any of the three having a vacancy. Because of its urban location and the large surrounding population, Montebello's waiting list for admission is constantly much longer than either of the other two.

Each application received is reviewed by the admissions committee consisting of the Superintendent, the Director of Physical Medicine, and the Medical Director or Chief Physician. Applicants suitable for admission are classified according to the following criteria:

Class I Applicants with a good potential for rehabilitation either in medicine or physical medicine.

Class II Applicants with such severe disability that the outcome of rehabilitation is doubtful but who the committee feel should be given a trial period in a chronic disease hospital.

Prior to the admission of a Class II applicant, the family or responsible relative is interviewed. They are informed that if no progress toward rehabilitation is made during a trial period of six to eight weeks, they should be prepared for the discharge of the patient.

Class III Terminal patients, or those requiring nursing care that cannot be administered except in a hospital.

Class IV Patients previously cared for in one of the chronic disease hospitals who require readmission for additional chronic hospital care.

Applicants for admission are rejected only after careful investigation which may include personal discussion of the patient with the family physician, home visits by the Instructive Visiting Nurse Association or County Public Health Nurses, and, in some instances, visits by the patient to the hospital for formal evaluation.

Patients

Approximately one half of the patients admitted to chronic disease hospitals are candidates for rehabilitation in physical medicine. A recent analysis (8) of the first 144 patients at Montebello Hospital to reach maximum benefit in physical medicine showed that the age of the patients ranged from 17 to 85 years, the mean age being 55 years. The patients in this group were referred to physical medicine because of the following conditions and disabilities:

Hemiplegia	57
Paraplegia	6
Quadriplegia	8
Multiple sclerosis	11
Other neurological diseases	17
Fractures	15
Amputations	4
Other orthopedic conditions	2
Arthritis	16
Generalized arteriosclerotic disease	5
Miscellaneous medical conditions	3

Medical patients and patients for custodial or terminal care account for about fifty per cent of the current census in the hospitals.

The medical staff is continually concerned with medical problems in patients admitted primarily for physical rehabilitation (8). Medical responsibility includes not only dealing with intercurrent medical complications in these patients, but also treating major medical problems. Numbers of hemiplegics suffer from arteriosclerosis, hypertension or diabetes. Patients with spinal cord injuries frequently develop muscular spasms, urologic complications, or decubitus ulcers, and patients with arthritis are usually under active treatment by both the medicine and physical medicine groups.

Other patients are essentially problems in medical rehabilitation. Any chronic disabling condition amenable to improvement is included in this category. Some patients are problems in diagnosis, some are problems in regulation, while others require convalescent care after trauma, illness or surgery. The hospitals have admitted patients with asthma, exfoliative dermatitis, chronic heart disease, ulcerative colitis, diabetes, and scleroderma. These patients present many problems for investigation. The hospital, we believe, can provide a greater

service in the area of medical and nursing rehabilitation than has been realized.

Custodial patients are those with relatively stable chronic conditions requiring constant medical or nursing care. Examples are high spinal cord lesions, chronic congestive heart disease, myasthenia gravis and severe ankylosing arthritis. If this type of patient can be cared for satisfactorily in a nursing home, hospitalization is economically unsound. The number of custodial patients admitted to each hospital has been inversely proportional to the adequacy of nursing home facilities in the respective areas.

Terminal patients are those with progressively fatal diseases in the late stages. Examples are malignant tumors, and progressive muscular or neurologic diseases. Intractable pain, extensive ulcerations or the need for specialized nursing care may be the indication for admission.

Hospital Programs

Each of the three hospitals has diagnostic facilities, including laboratory and X-ray, and all patients are completely evaluated on admission. A dentist sees all admissions and necessary repairs are made. In some instances, dentures are fitted. An ophthalmologist does refractions and glasses are obtained when indicated. Chiropodist service is provided in all three hospitals. Hearing tests are done when necessary and at times hearing aids are fitted. A speech training program for aphasics is available at Montebello and has been planned for the other hospitals. Through the cooperation of the Speech and Hearing Society of Baltimore, hard of hearing patients can be trained in lip reading. This service is provided only in the Baltimore hospital. For the most part, the same facilities for medical care and rehabilitation are present in each of the three hospitals. Generally, patients need not be transferred from one hospital to another. However, exceptions have been made when a specialized service is available only in one of the other chronic disease hospitals.

As soon as possible after admission, the patient is presented at a group evaluation clinic where representatives of the medical staff, physical medicine staff, nursing staff, and social service staff evaluate and summarize the medical and physical conditions of the patient and outline a program of therapy. The patient's individual problems are discussed with his family and with the patient himself. Visiting public health nurses, vocational rehabilitation counselors, and members of the clergy frequently attend these conferences when patients in whom they have an interest are presented.

From the beginning it was planned that the hospitals should be located near accredited general hospitals so that specialists and special facilities would be convenient. Each of the hospitals has utilized as consultants the services of various medical and surgical specialists including psychiatrists.

From Montebello, for example, a surgical emergency is accepted immediately by the University Hospital. Patients requiring elective surgery are seen by a surgeon prior to transfer and the optimum time is chosen in conference with the medical and physical medicine staff. Should a patient request a surgeon of his own choice and if a satisfactory arrangement can be made, such a request is promptly granted. Consultants in other specialties, including gynecology and dermatology see patients on request. An ophthalmologist and a radiologist make weekly visits.

The Departments of Neurology, Neurosurgery, Urology and Orthopedics of the University of Maryland Medical School and Hospital use Montebello for teaching purposes. Visiting staff, house staff, and students in these departments hold clinics at regular intervals. Nursing students in the degree program of the University of Maryland School of Nursing began an affiliation program with Montebello Hospital in 1956. During the academic year an instructor is assigned to Montebello to direct these activities in cooperation with the Medical Director and the Nursing Service.

The hospitals' budget for the current fiscal year provided, for the first time, a full time

pathologist and research director. A laboratory is being provided at Montebello Hospital. All material from the three hospitals will be processed, studied, and diagnosed at this central laboratory. Monthly clinical-pathologic conferences are planned at each of the three hospitals. Laboratory space and facilities for research are also being provided. Investigations will be directed toward problems in the prevention, diagnosis and treatment of chronic diseases.

Discharges

In accordance with the wording of the Act of 1943 (1), custodial care was a major part of the program in the early days. With increasing emphasis on rehabilitation, less and less of the hospital population consists of custodial patients who can be cared for more economically in nursing or boarding homes. With the changing hospital population, more time must be devoted to discharge planning.

Because the public frequently has the impression that admission to a chronic disease hospital is for life, it is necessary to begin discharge planning even before admission. Class I and Class II applicants, admitted for rehabilitation, can expect discharge when maximum hospital benefit has been reached. Families must be made aware of this and all plans for discharge of the patients must include the families.

Depending on the degree of independence achieved during hospitalization, patients may be discharged to their own homes, boarding homes or nursing homes. A small number of patients who are mentally deteriorated on admission or become so during hospitalization, are discharged to mental hospitals. During the fiscal year 1957–58, 206 patients were discharged from the chronic disease hospitals—69 per cent to their homes, 6 per cent to boarding homes, 16 per cent to nursing homes, and 8 per cent to mental hospitals.

Employment plans for patients able to work also begin early during hospitalization. The staff cooperates closely with the State Vocational Rehabilitation Counselor. Psychological tests are made and pre-vocational training, if necessary, is started. In selected cases, patients are given a trial work period while still living in the hospital.

Summary

The history of the chronic disease hospitals in Maryland is traced from the almshouse era of custodial care to the present day operation of three modern hospitals emphasizing rehabilitation.

Applicants for admission to the chronic disease hospitals are divided into three principal categories: those who are expected to benefit from rehabilitation in physical medicine; those who will benefit from prolonged medical management; and those with chronic progressive fatal disease requiring extensive medical or nursing care.

The principal function of the chronic disease hospitals is rehabilitation.

The three hospitals are organized as a unit under the direction of a Superintendent, a Medical Director and a Director of Physical Medicine. Facilities for rehabilitation and medical care are duplicated throughout. Each hospital is closely associated with an accredited general hospital.

Patients are discharged after they have reached maximum hospital benefit. During the fiscal year 1957–58, 206 patients were discharged; 69 per cent of these returned to their own homes able to contribute to the welfare of their families.

Montebello State Hospital
2201 Argonne Drive
Baltimore 18, Maryland

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CHARACTERISTICS OF NURSING HOMES IN METROPOLITAN BALTIMORE*

MATTHEW TAYBACK, Sc.D.,[1] HERBERT G. FRITZ[2] AND JOSEPH P. CONTE[3]

Introduction

When considering the medical problems of the aged, one is quickly faced by the exceptional needs of those individuals of advanced age who are institutionalized for a long, indefinite period of time. The type of institution concerned may be a mental disease hospital, a chronic disease hospital, a nursing home or an old age home. This discussion is concerned with the characteristics of those individuals who are patients in nursing homes licensed as such by the Maryland State Department of Health. In addition, data is provided and inferences are drawn in connection with the characteristics of, and with the medical and ancillary services presently provided in, such nursing homes. The purpose of this presentation is to assist in the formulation of constructive, responsible medical opinions in regard to the adequacy of present medical practices in nursing homes and to assist in a proper appreciation of the role of the nursing home in the care of the aged sick.

Public interest in the nursing home has developed as a result of four factors. Demographically, it is clear that the number of persons, as well as the per cent of total population, in advanced age groups has increased rapidly within recent decades. Sociologically, the trend towards urbanization has led to smaller households and a decline in the practice—common in rural family life—which provided for the care of older members by the younger ones in a household. These trends have increased substantially the numbers in need of nursing care for a prolonged period in a setting other than a private household. Because of the quasi-hospital nature of the nursing home, and in view of the serious accidents which inadequate physical standards produce, responsibility for the licensing of nursing homes was vested in the State Board of Health through legislation passed in 1945. Finally, the establishment of stable programs for public assistance of aged indigent individuals has resulted in a substantial experience by welfare departments concerned with money grants to aged clients having nursing care needs. In this connection, the issue of cost of care and of desirable standards of care has been a subject of continuing interest during the past four years.

As a by-product of its licensing program, the Maryland State Department of Health can provide a broad framework of information concerning the numbers and locations of nursing homes in Maryland; the number of beds available; the census of patients at a specified time; and certain data on the physical standards of specified nursing homes. A total of 3,818 beds in nursing homes were licensed in 1958. Considered on a population basis, there were 1.35 beds per

* Prepared for the Geriatrics Committee of the Medical and Chirurgical Faculty of Maryland. September, 1958.

[1] Assistant Commissioner of Health, Baltimore City Health Department.

[2] Chief, Division of Hospital Services, Maryland State Department of Health.

[3] Health Program Representative, U. S. Public Health Service.

1,000 population, which compares favorably with the standard of 1.5 approved by the State Board of Health in 1956. However, only 826, or 22 per cent, of these beds are in suitable structures when evaluated from the point of view of construction and design. We shall not concern ourselves here with this facet of the nursing home problem.

Study Procedures

For purposes of this study, the Baltimore metropolitan area was defined as including Baltimore City and Baltimore County. Within this area, each of the licensed nursing homes was visited during July and August by a public health nurse or by a medical student. During the visit, a responsible member of the nursing home staff was queried with reference to the number and type of nursing personnel employed; the methods by which physician care is rendered; and the availability of such ancillary services as occupational therapy, physical therapy and organized daily activity programs.

A complete census provided data on age, sex, race and financial status of each nursing home patient. In addition, for every third patient—a 33⅓ per cent sample—diagnosis, length of stay in home, frequency of physician care and other medical services was ascertained. For patients receiving public assistance, a Barthel Index[4] was computed. Following a subsample check to determine whether valid information was being provided by nursing homes, a questionnaire was mailed to each physician named as the personal physician of an inmate. The doctor was asked the diagnosis; the time of most recent visit, and to estimate how often his patient should be visited.

General Characteristics of Nursing Homes

Within the area surveyed, there were 61 nursing homes with a census of 1,775 patients. According to records of the Maryland State Department of Health there are 1,950 beds in these homes. When this survey was made the institutions visited were operating at a 91 per cent occupancy rate. This is considered efficient utilization of facilities. The population of the city and county on July 1, 1958 was approximately 1,400,000. Therefore, there were 1.3 nursing home beds per one thousand persons.

The sizes of the nursing homes in the metropolitan area are shown in Figure 1. The most common unit has less than twenty beds. Three out of four homes have less than forty beds. It is essential that this characteristic of nursing homes should be kept in mind when consideration is given to the medical capabilities of these institutions. The staffing arrangements varied considerably. In twenty-seven homes (44 per cent of the total) there were no registered professional nurses employed. In these places, there was usually a licensed practical nurse on the staff. However, in seven of the smaller homes, neither a professional nurse nor a licensed practical nurse was employed. On an average there were provided 17.5 hours of nursing and personal care per patient per week. (The minimum State standard for licensing is 14 hours per week per patient.) In addition, 12.5 hours of non-nursing category were provided to cover preparation of food, maintenance of the home, etc. About 30 hours of various skills were provided weekly per patient.

In view of the exceptional variation in size and staffing arrangements among the nursing homes an opinion was sought from nurses on the staff of the Division of Hospital Services of the Maryland State Department of Health as to the capabilities of the individual homes for providing skilled nursing care. A summary of these statements indicates that 33 (54 per cent) of the homes are capable of rendering skilled care while the remaining 28 are only able to provide personal care, without skilled nursing, or to provide sheltered home facilities.

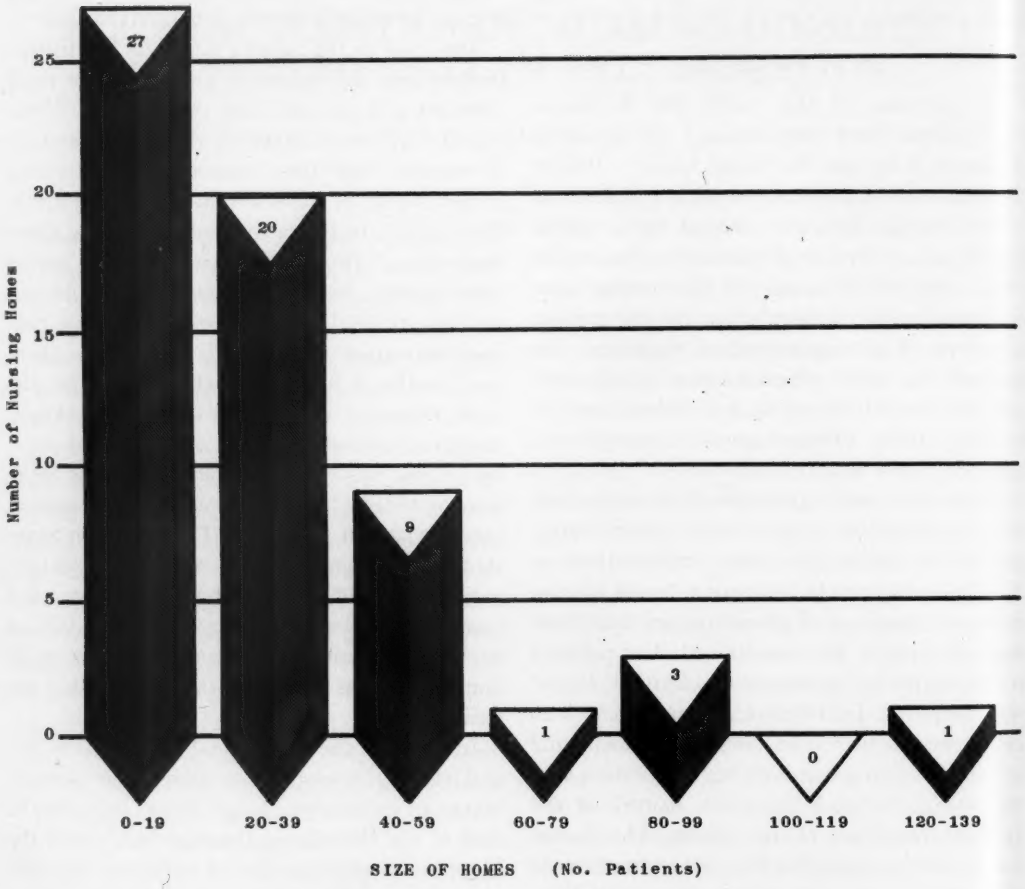
In Table 1 will be found an indication of the availability of several other services desirable for nursing homes. Only in the case of day space

[4] The Barthel Index is used by the State Chronic Disease Hospital staff to evaluate the ability of the individual to perform such basic acts as functional use of extremities; control of toilet functions, etc.

FIG. 1

DISTRIBUTION OF NURSING HOMES BY SIZE

METROPOLITAN BALTIMORE, 1958



(a place where the patient can spend part of the day outside of his room) was there evidence of uniform provision of the services required to transform the nursing home from a "terminal station" to a tolerable and human environment pervaded by a modicum of the positive aspects of living. It may be added that it is beyond reasonable expectation to find full-time personnel in occupational therapy, physical therapy or in supervision of organized activity programs when the usual nursing home is a facility housing less than 25 persons. It is, however, well within practical consideration to provide such special services on a part-time basis either by contract with the Instructive Visiting Nurse Association or through home care programs sponsored by general or State chronic disease hospitals.

THE NATURE OF PATIENTS IN NURSING HOMES

The age, sex, and race distribution of patients

TABLE 1

Scope of Services Provided by 61 Nursing Homes in Metropolitan Baltimore, 1958

Service	Nursing Homes Providing Services	
	Number	Percentage of Homes
Provides day space	53	87
Skilled nursing care	33	54
Organized activity program	19	31
Occupational therapy program	10	16
Physical therapy program	8	13

TABLE 2

Distribution of Nursing Home Patients by Age, Race and Sex in Metropolitan Baltimore, 1958

Age Group	Grand Total	White			Nonwhite		
		Total	Male	Female	Total	Male	Female
Under 55	49	36	14	22	13	4	9
55-64	132	87	47	40	45	18	27
65-74	383	324	91	233	59	22	37
75-84	730	673	155	518	57	17	40
85 and over	455	418	87	331	37	12	25
Unknown	26	20	4	16	6	2	4
Total	1,775	1,558	398	1,160	217	75	142

in nursing homes is given in Table 2. Several observations which may be made from these data are somewhat unexpected. Almost three out of four patients are women (73.4 per cent). Although Negroes constitute 22 per cent of the city-county population they comprise only 12.2 per cent of nursing home patients. This may be due in part to the relatively young nature of the Negro population in the metropolitan area. It may also be a reflection of the limited facilities available to this segment of our population.

It is worthwhile to note that 90 per cent of patients are 65 years of age and over. Further, the median age of these patients is 77 years. The nursing home thus appears to be not a convalescent facility concerned with returning individuals to active productive roles but is largely absorbed in the care of individuals whose duration of stay or need of rehabilitative effort is indefinite and vague. Information on length of stay is given in Table 3 according to diagnosis at admission. These figures do not represent

TABLE 3

Admission Diagnosis of Nursing Home Patients by Length of Stay

Admission Diagnosis	Total	Length of Stay (Years)						
		Under 1	1	2	3	4	5-9	10 and over
Diseases of the heart	176	76	35	15	12	13	24	1
Vascular lesions of the central nervous system	97	34	18	14	12	7	12	—
Senility	71	32	8	9	8	7	7	—
Accidents	47	23	11	4	5	1	3	—
Arthritis	32	7	5	3	3	3	9	2
Senile psychoses	26	11	5	4	1	3	—	2
Diabetes	23	7	4	1	5	4	2	—
Cancer	20	12	3	2	—	1	2	—
Diseases of the digestive system	11	4	4	2	—	—	1	—
Diseases of the eye and ear	8	3	2	1	—	—	1	1
Anemia and malnutrition	8	2	—	2	—	2	2	—
Diseases of the genital organs	5	4	1	—	—	—	—	—
Respiratory diseases	4	1	—	1	—	2	—	—
Diseases of the veins	4	1	—	2	1	—	—	—
Amputee	7	4	2	—	—	1	—	—
Nephritis and nephrosis	2	2	—	—	—	—	—	—
Tuberculosis	2	1	—	—	1	—	—	—
Other diseases	9	2	1	2	—	2	2	—
Non-medical	21	6	1	3	3	—	7	1
Unknown	20	5	9	2	1	—	2	1
Total	593	237	109	67	52	46	74	8

completed length of stay generally obtained by analysis of discharges. At the time of survey, 30 per cent of all patients had been in the nursing home for three or more years. Diseases of the heart, vascular accidents affecting the central nervous system, arthritis, and senility were the principal conditions accounting for extended residence. In addition to these disease entities, diabetes and fractures were the important medical problems present on admission to a nursing home.

On whose initiative are elderly individuals placed in nursing homes? The answer to this question may be found in the accompanying

TABLE 4

Distribution of a Sample of Nursing Home Patients by Source of Referral in Metropolitan Baltimore, 1958

Source of Referral	Number Referred	Per Cent Referred
Total	568[1]	100
Patient's family	263	46
Family physician	133	24
Welfare department	88	16
General hospital	48	8
Other nursing home	26	5
Chronic disease hospital	5	1
Mental hospital	5	1

[1] Excludes 25 patients for whom source of referral was not stated.

Table 4. In 46 per cent of admissions to nursing homes, relatives of the patient were the principal source of referral. Only an insignificant fraction of admissions developed as a result of transfer from a chronic disease or mental hospital.

Medical Care Practices

The very limited size of nursing homes precludes the employment of a full-time resident physician in these institutions. Licensing standards require that each patient have a personal physician and that the nursing home be served by a principal physician who advises on medical problems and policies and responds to emergencies. The general pattern is one where the principal physician is also the attending physician for several or more patients. It is usual in homes of ten or more patients to find more than one physician in attendance. The physician may be called in case of need by a member of the nursing home staff although in 42 per cent of nursing homes this decision can only be made by the registered or licensed practical nurse.

An index of the quality of medical care rendered is provided by the frequency of visits made to the nursing home patient. Analysis of this type of information which appears in the last row of Table 5 indicates that 59 per cent of patients had been seen within the month prior to survey. At the other end of the scale, 10 per cent had not been seen in the six months prior to this study. Interpretation of these data is somewhat difficult in the absence of acceptable criteria. It is, however, of interest that several differences of note have been found when the city nursing home experience is compared with the county experience. Private patients in the city are visited more often than such patients in the county. Welfare patients in the city are visited less often than welfare patients in county nursing homes. Furthermore, the pattern of visiting in the county homes does not differ according to the financial status of the patient but a difference exists in the city. The significance of these data will be discussed in a later section of this report.

It is relevant in a study of the medical care afforded nursing home patients to inquire into the rate of hospitalization, the consultation rate and into the frequency with which hospital outpatient services are utilized. The question asked

TABLE 5

Time of Last Patient-Physician Contact by Location of Nursing Home in Metropolitan Baltimore, 1958

Location	Number of Patients Sampled	Time of Last Patient-Physician Contact											
		<7 Days		8–30 Days		31–90 Days		3–6 Months		6–12 Months		None In Past Year	
		No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Baltimore City Nursing Homes													
Welfare	148	25	16.9	30	20.2	35	23.7	35	23.7	6	4.1	15	10.1
Private	217	89	41.0	69	31.7	27	12.4	14	6.5	3	1.4	13	6.0
Baltimore County Nursing Homes													
Welfare	44	15	34.1	8	18.2	15	34.1	1	2.3	2	4.5	2	4.5
Private	184	61	33.2	52	28.3	36	19.6	17	9.2	10	5.4	8	4.4
Total	593	190	32.0	159	26.8	113	19.1	67	11.3	21	3.5	38	6.4

to obtain such information was, "Within past year has patient: (A) Been hospitalized? (B) Received service in an out-patient department of hospital or clinic? (C) Received services of specialist at the nursing home or in physician's offices?" with yes or no responses elicited to each service. Information secured on 591 patients indicated that 52 (9 per cent) had been hospitalized within a year prior to the survey, 7 per cent had visited an out-patient service and 6 per cent had received the benefit of services of a specialist. Once again, without known criteria, it is difficult to assess the implications of these data. Certainly, they can serve as a base for comparison with later surveys of this type. The rate of hospitalization is below the average national Blue Cross experience. As standard medical record practices are established it should prove possible to employ these utilization indices for constructive evaluation of the level of care afforded in individual nursing homes and in different communities.

The Welfare Patient

One of the principal categories of public aid is known as Old Age Assistance (OAA). In recent years, this program has been the base of public financing of nursing home care for persons 65 years of age and over who lack the means of paying the cost of such service. At the present time the monthly grant for full-time nursing care is $115.50 per month or $1,386 per year. This is supplemented by professional services and drugs provided under the medical care programs. The distribution of nursing home patients by financial status is given in Table 6. Among the total of 1,775 patients in nursing homes located in the city-county area, 579 or 32 per cent are patients whose costs are met from public funds. In the instance of nonwhite patients, 95 per cent are individuals whose care is covered by public funds. The ratio for white patients is 24 per cent.

The nursing home patient supported by public funds presents a particularly difficult problem for a number of reasons. Although the grant per year, $1,386, is by no means inconsequential, it is commonly questioned whether this rate of pay is adequate to provide an acceptable level of nursing care. Furthermore, this rate of pay is wholly insufficient to cover the expenses of those patients requiring intensive nursing services. Some indication of what the welfare patient can command in the way of nursing home care is provided by Table 7. In the 35 nursing homes where less than 20 per cent of the patients were supported by public funds, 5.2 nursing hours per patient per week were provided and a total of 34.3 staff hours weekly. In those homes where more than 60 per cent of patients were supported by public funds, 3.4 nursing hours per patient per week were provided and the total hours were 26.3. Service to welfare patients was in general about two-thirds of that afforded to private patients. It is not unreasonable to presume that this is an inevitable adjustment of services to the fees paid per welfare patient.

In Table 5, the frequency of physician visits to welfare patients is shown for city and county

TABLE 6

Nursing Home Patients According to Financial Status in Metropolitan Baltimore, 1958

Financial Status	Total		White		Nonwhite	
	Number	Per cent	Number	Per cent	Number	Per cent
Total	1,775	100	1,558	100	217	100
Private (full pay)	1,196	68	1,185	76	11	5
Full public assistance	455	25	282	18	173	80
Part public assistance	124	7	91	6	33	15

TABLE 7

Staff Hours per Patient According to Percentage of Welfare Patients in Nursing Home in Metropolitan Baltimore, 1958

Per Cent of Welfare Patients In Nursing Home	Number of Nursing Homes	Total Number Of Patients	Average Hours per Patient per Week				
			Professional nurse	Practical nurse	Nursing aides	Other staff	Total staff
0–19	35	979	2.4	2.8	14.7	14.4	34.3
20–59	13	263	2.4	2.2	8.7	9.0	22.3
60–100	13	533	1.3	2.1	11.9	11.0	26.3
All Homes	61	1,775	2.1	2.5	13.1	12.6	30.3

nursing homes. It was apparent that in the county, welfare patients were visited more frequently than similar patients in the city, even though the opposite pattern was true for private patients. One must avoid making inferences that these differences are indicative of significant variation in quality of medical care. Nevertheless, the matter requires careful inquiry. Services of a physician for welfare patients in county nursing homes are reimbursed on a fee for service basis. In the city, such services are obtained on a per capita payment plan. It would appear that these alternate methods produce different patterns of frequency of care. The obvious questions which arise are whether the city scheme is more economical and whether the county scheme produces a more adequate level of care.

The public expenditure for nursing care in the metropolitan area may be estimated conservatively at $750,000. Do the 579 patients require the comparative expensive residence of a nursing home? Approximately 17 per cent were classified by the study staff as personal care patients, not requiring special nursing skills nor confined to bed. The special requirements of disabilities characteristic of the remaining welfare patients are summarized in Table 8. Of the total patients supported by public funds 41 per cent are estimated to require intensive care. The remainder could possibly be housed elsewhere than in a nursing home, if say, a visiting nurse service and a private household were available. It cannot be said with certainty, however, that such an alternative would result in a per capita reduction in cost.

TABLE 8

Selected Characteristics of Welfare Patients in Nursing Homes in Metropolitan Baltimore, 1958

Category	Number	Per Cent
Total	579	100
Personal care only	101	17
Nursing care	478	83
Confined to bed	240	41
Incontinent	216	37
Require medication	321	57
Require dressings	99	17
Receive therapeutic diet	171	30
Require other special treatments	180	31

SUMMARY

In a consideration of the medical care problems of the aged, the especial needs of individuals institutionalized in a nursing home are worthy of careful study. This paper is concerned with the results of a survey of the 61 nursing homes in Baltimore City and Baltimore County, described here as metropolitan Baltimore.

A total of 1,775 patients was enumerated at the time a census was taken in the summer of 1958. The median age of these individuals was 77 years, and 75 per cent of the patients were female. The principal conditions cited at admission were: diseases of the heart, vascular lesions of the central nervous system, senility, accidents and arthritis.

In an examination of medical care practices, it was found that 59 per cent of patients had been seen within the month prior to survey. Other rates of utilization are provided. A particularly interesting finding was the difference, city versus county, in physician visiting practices in connection with welfare patients. Several additional details concerning the problem of the welfare patient in nursing homes are provided.

Although some of the data, here presented, have proved difficult of interpretation it is to be expected that surveys of the type described will be repeated in years hence and comparative time trends can serve to guide us in evaluating the services provided to nursing home patients.

Baltimore City Health Department
Baltimore 3, Maryland

Maryland State Department of Health
2411 North Charles Street
Baltimore 18, Maryland

GERIATRICS—BRIEFS AND ABSTRACTS

HERMAN SEIDEL, M.D.

For the busy practitioner whose free time is limited, Briefs and Abstracts can serve a very useful purpose.

Geriatrics is a young topic. Reports and studies providing information on activities in that field are as yet not widespread and not within reach of the vast majority of physicians.

The following briefs and abstracts are mainly derived from a supplement to the *Journal on Gerontology* published by the American Gerontological Society, from the *Journal on Geriatrics* of the American Geriatric Society and from the *Journal Geriatrics*, published in Minneapolis under the editorship of Dr. Walter C. Alvarez, and the *Archives of Internal Medicine.*

These selections have been made with the intention of providing information on the general status of Geriatrics. The excerpts from Supplement Number 1 of the *Gerontologic Journal* provide information as to the development and progress of Geriatrics in European countries. The reports were given by outstanding authorities and are very informative. It is enlightening to note that our European colleagues and communities are not only not behind us but in many ways are a step or two ahead of us.

These briefs and abstracts are presented with the hope that they contain helpful and gratifying information.

From the Preface by JAMES E. BIRREN, editor of the *Journal of Gerontology*—Supplement No. 1, p. 1.

"It is not pretentious to think that serious pursuit of gerontology will have dramatic consequences for man's wellbeing and actions. Clearly, this symposium is another promising child of gerontology, born of the good intellectual parentage of the participants. The program committee is proud to have assisted the participants in the 'delivery' and it anticipates a vigorous and productive future for the offspring."

A World View of Gerontology, by ROBERT J. HAVIGHURST, Ph.D. Gleaning from his Remarks.

"Gerontology is both an applied and a pure science. As an applied science it utilizes our knowledge of aging to make life longer and more satisfying. As a pure science it seeks knowledge about the aging of animals and men, both individually and in population aggregates."

Problems of General Biology of Aging, F. VERZAR, Dr. Med., Prof. emer. Physiology (University of Basel, Switzerland), *Journal of Gerontology*—Supplement No. 1, p. 6.

Dr. F. Verzar is one of the four guests who presented European Gerontology at the Cleveland Convention of the American Gerontology Society.

"The present attitude toward experimental research on aging suffers from the mistakes which were made a generation ago, and it might therefore be interesting to consider what these were. First of all, we no longer see the aim of gerontologic research in the same way as fifty years ago. At that time the goal was the prolongation of human life. Now we have reached a state where, because of advances in hygiene and medicine, more people live to become old and the proportion of old people has thus increased to the extent that the new aim is to keep these older people in a healthy state for an enjoyable and active life. The second new point of view is that only such experiments which have scientific validity and are not based simply on subjective opinion or on one-sided observations are now acceptable; they must have all the criteria which are required in any physiologic study.

"I might remark that even the explanation of the primary fact, that visual accommodation decreases with age because of the decrease of elasticity of the lens, is not really settled. A distinct role is played by the tonus or the force of

the ciliary muscle. It is interesting to see how this can be influenced by psychic factors, leading to astonishing changes in the visual capacity of old persons if they are brought from an old age home to a summer holiday place.

"The greatest adaptation process is birth itself, when the individual is transferred to completely new life conditions. We therefore propose that problems of early evolution until puberty should not be mixed up with research on aging.

"It is only through adaptation by psychic capacities that it is possible for man to survive longer, for only man is able to transfer the experience of a lifetime to the next generation, and to be still a useful member of society.

"The mechanism of adaptation has not been explained definitely as yet. Endocrine activities of thyroid, adrenal, and pituitary are not responsible for the quick adaptation, and here again we believe that *the disturbance lies in the decreasing capacity of the central nervous system for heat regulation.*"

A Survey of Clinical Investigations on Aging Published in Europe after The Second World War, by TORBEN GEILL, M.D. (Medical Director, De Gamles By, Copenhagen), *Journal of Gerontology*—Supplement No. 1, p. 25.

Dr. Torben Geill is another one of the four. His remarks on thrombosis are most enlightening and timely for us Americans who are rather reluctantly initiating the use of anticoagulants. His figures on the results obtained are rather impressive.

"In extensive material obtained at autopsy at De Gamles By (The Geriatric Hospital), Copenhagen, Bruzelius found fresh myocardial infarctions in 4.1 per cent and sequelae of coronary occlusion (major myofibroses) in 20.7 per cent. Thrombosis of the venous system, particularly emboli and thrombi of the pulmonary artery, seem to have become considerably more common than previously (Brull). According to Geill, a geriatric autopsy series from De Gamles By showed emboli and thrombi of the pulmonary artery in 23.7 per cent.

"It must be endeavored, therefore, to develop simple methods for disclosing a tendency to thrombosis, particularly in elderly persons, in order to initiate prophylactic measures in time. The importance of such prophylaxis is indicated by the modern long-term treatment with anticoagulants of the dicumarol type. According to Dalsgaard-Nielsen and Skinhoj, who treat *cerebral thrombosis* with anticoagulants, this therapy lowers the mortality from about 30 per cent to 5.8 per cent. The lowered mortality seems to be caused by a reduction in the occurrence of thromboses in the venous system with subsequent emboli to the pulmonary arteries."

Dr. Geill's Condensed Review on the Work in Europe on Arteriosclerosis.

Significance of Nutrition

According to a number of European workers, disturbances in the cholesterol metabolism, especially with a diet too high in cholesterol and animal fat, is the cause of arteriosclerosis. It is interesting to consider the findings in the Scandinavian countries during the last World War and the first post-war years. In Finland, Sweden, and Norway, the mortality from arteriosclerotic diseases, particularly cardiac diseases, decreased during these years in which nutritive restriction involved a marked reduction in the consumption of eggs, butter, and pork, which considerably exceeded those in the other Scandinavian countries. Consequently, such a fall in the mortality from atherosclerotic lesions was not observed in Denmark. The increasing consumption of the above mentioned animal products during the post-war years has again raised the mortality from those diseases in the Scandinavian countries.

Rape-seed oil has a moderate effect, and olive oil only a slight effect. Coconut fat (both hydrogenated and non-hydrogenated) had no effect at all. Among the animal fats, milk fat showed an enhancing effect on the cholesterol level, while whale oil depressed it. This last fat can hardly be used for human consumption in a non-hydrogenated form, and if it is hydrogenated it loses its cholesterol depressing effect. The authors con-

clude from their experiments that the cholesterol-depressing effect of certain fats is related to their content of polyunsaturated fatty acids.

Attention Is Drawn to Heparin

"Most workers are agreed that administration of heparin can normalize the blood picture in elderly persons (Antonini; Antonini, Piva, Salvini, and Sordi; Antonini and Sordi; Antonini and Pica; Coppo, Lorenzini, and Innocenti). Galletti and Abbati, on the other hand, did not find any alterations in the concentration of serum glycoproteins in elderly persons within the first four hours after intravenous injection of 100 mg. heparin."

Sex *Hormones* and Atherosclerosis

"The influence of the sex hormones on the development of atheromatosis has been studied by Magrini, who thinks that the sex difference in the incidence of atherosclerosis is caused by a difference in the concentration and distribution of the plasma lipids in the two sexes, especially up to old age. His findings permit the presumption that ovarian function is the main factor which protects premenopausal women from atherosclerosis. During estrogen therapy, Magrini observed that in patients with a history of myocardial infarction, the lipoprotein pattern—already shifted to the atherogenic side—showed a tendency to become normalized and took on an appearance characteristic of young people. Testosterone, on the other hand, gave pronounced atherosclerotic changes in the plasma lipoprotein pattern."

Dr. Geil's Summary on Atherosclerosis.

"The European studies reviewed above afford evidence that the development of atherosclerosis is due in the main to nutritional factors, chiefly the presence of saturated fatty acids and cholesterol in the food, but that other factors too, particularly hypertension, are of decisive significance. The intimate correlation between arteriosclerosis and thrombus formation in the arteries has been further established by a number of investigators. In future studies on the pathogenesis of arteriosclerosis, increased regard must be paid, therefore, to the triad arteriosclerosis-blood coagulation-thrombosis."

From Dr. Geill's Notes on Heart Diseases.

The occurrence of auricular fibrillation in the aged has been reported by Corti and Gallini. They succeeded in abolishing this sign in 93 per cent of the patients, *invalidating the previous view that auricular fibrillation in the aged is fairly intractable.*

"*Studying the seasonal fluctuations in the mortality from arteriosclerosis as shown by the medical statistics of various countries.*"

"From Hansen found a maximum in the coldest and a minimum in the hottest month of the year, irrespective of whether the country was north or south of the equator. The most marked difference between the mortality in the coldest and hottest month was in England and Portugal. Seasonal variations for cerebral and for cardiac arteriosclerosis were of the same magnitude."

Dr. Geill's Survey on Anemias.

"Taglioni and Burlina stress that pernicious anemia occurs predominantly in elderly persons, but that it is often masked by other diseases, particularly of the cardiovascular system. Pernicious anemia is common, and hypochromic anemias caused by hemorrhages and infections are often refractory to treatment. Genuine essential hypochromic anemia is rare.

"According to Echerstrom, sideropenic anemia in elderly people is *often associated with ulcers of the leg.* Effective iron medication may cure the anemia as well as the ulcerations. Berselli and Rizzente have obtained good results by treating hypochromic anemia in elderly cancer patients with intravenous iron and amino acids."

Dr. Geill's Survey: Metchnikoff's Autointoxication Theory is Revived.

"The intestinal flora in old people was studied by Orla-Jense, Olsen, and Geill, and a re-examination of Metchnikoff's hypothesis carried out. Since yoghurt bacteria grow but poorly in the animal and human colon, they are not suited for the purpose of suppressing the putrefactive processes arising in the colon. If the colon in certain diseases is in need of a change of its

bacterial flora, this change should be produced by means of milk cultures of the lactic acid bacteria characteristic of the normal colon, viz., Bacterium bifidum and thermobacterium intestinale. Normally these bacteria (especially the former) are present in ample amounts in the human colon. Feces from old people show on the average more putrefactive bacteria and less Bacterium bifidum than feces from young and healthy people. When the acid production fails, as it does with advancing years, there is a greater chance for the salivary streptococci, Streptococcus salivarius, to pass unscathed through the stomach. The reason that the putrefactive processes in the colon increase when the hydrochloric acid production in the stomach diminishes is not only to be found in the poorer digestion of the proteins but also in the circumstances that the food, instead of being almost sterile when it leaves the stomach, is so filled with bacteria that the carbohydrates are already fermented in the small intestine. The last mentioned condition seems to be improved if only a little amount of hydrochloric acid (2 or 4) tablets of betaine-hydrochloride, each 0.25 Gm.) is consumed in connection with the chief meals."

Dr. Korenchevsky Extends the Theory of Autointoxication Much Beyond Intestinal Putrefaction.

"During recent years, Korenchevsky has particularly devoted himself to the hypothesis that changes of aging represent autointoxication. At the symposium for experimental research on aging in Basel, 1956, one of the sessions was reserved for autointoxication. Korenchevsky, reviewing the various forms of autointoxication, concluded that the most probable theory of old age seems to be the 'self-destruction theory.' In his opinion, it explained 'physiological aging, physiological span of life, physiological death, and their fixed characteristics in each species by the inherent deficient nature of physicochemical structure and of the endogenous processes of the organism.' He stated that the theory was supported by the toxic properties of some proteinic metabolites and certain hormones normally present in the blood and tissues of the organism."

An apropos and terse summary by Dr. Geill on Orthopedics is very applicable to the state of affairs in our own country.

"A feature such as happiness of the patient cannot be measured as a statistical figure, but when considering crippling disabilities in the old it is really their mobility and capacity to get about, their independence, and their relative freedom from pain that should be the guiding criteria. Surgeons are, however, so obsessed *by the question of mortality statistics that treatment is often denied to the old for fear that they may die as a result of it.* Hesitation is based partly on the fear that the skeletal system is incapable of repair or improvement in old people. This is a fallacy. Experience gained from fractures in old people shows that power of repair remains throughout life, if the vascular supply is good. Long periods of immobilization are not well tolerated, *but actual operations, if indicated, can be safely performed.* If the patient is already confined to bed, the indications for treatment are very clear, because the patient has nothing to lose.

Public Health and the Aged in Europe: Research and Programs, by R. J. VAN ZONNEVELD, M.D. (From the Section of Gerontology, National Health Research Council T.N.O., Netherlands Foundation for Applied Scientific Research). *Journal of Gerontology*—Supplement No. 1, p. 67.

"The main principles in looking after the well-being of the aged, now more or less adopted in Europe, are that *the aged have the same rights* as the younger age groups to the social and medical services provided by the community and that they should be enabled to live as independently as possible.

"The medical profession has to contribute to this objective by examining and treating the aged sick as effectively as possible and by cooperating with other agencies in preventing disablement and in restoring those who have been affected to their maximum possible independency.

"Occupational and recreational possibilities are also developing at a rapid rate. Many old

people prefer to go their own way and not be included in organized programs. This is one of the reasons why in some countries on the continent the system of clubs for the aged is not flourishing.

"In most countries, financial circumstances no longer are an important hindrance to medical examination and treatment. Under normal circumstances, *the general practitioner is considered the best man to look after the aged.* In case of severe diseases or defects, the hospital is the right place to start treatment.

"Nursing homes, which fall under the geriatric services where these exist, are also a special problem. Some are run for profit, they may give inadequate treatment; or they may not be subject to effective control. There is still no unanimity of opinion on the question of whether healthy and ill old people should be looked after in one and the same home. The tendency is to provide departments which are at least functionally separated.

"For the aged with mild mental disorders, the idea is to construct special nursing homes with a much more homelike atmosphere, where the accent is on the quickest possible rehabilitation. In some countries such homes can already be found. There is equal need for special departments for the seriously confused aged in the mental hospitals. Various countries have provided for such departments."

Functional Capacities of Older Individuals, by ERNST SIMONSON, M.D. (From the Departments of Ophthalmology and Physiological Hygiene, University of Minnesota, Minneapolis) *Journal of Gerontology*—Supplement No. 2, p. 18.

"The relationship of capacity for physical work to earning power can be discussed quite briefly; it is, for the large majority of industrial and all clerical occupations, negligible. The problem has been solved essentially by the industrial revolution. The process of mechanization has been continuous since about 1800, but was accelerated after the First World War, particularly in Germany. At that time, a fairly large percentage of heavy work was still present, but it was being rapidly diminished.

"We found the endurance of eleven older men with an average age of 53 years in running only half that of twenty-five young men with an average age of 33 years, which agrees fairly well with Dawson's results. The mechanical efficiency, on the other hand, is not affected until the age of 63 years, and only comparatively little at the age of 75 years.

"What are the limiting factors of physical performance as affected by age? One of the most important physiologic function is the maximum of oxygen intake, which determines the limit of anaerobic performance, the maximum level of prolonged aerobic work, and, in general, the cardiovascular reserve. Oxygen transport depends on heart rate, blood oxygen utilization, and cardiac stroke volume. Dill suggested that the inability of older people to raise the heart rate is the limiting factor. However, tachycardias of various types with heart rates equaling or exceeding those in maximum work of young men, are not uncommon in old patients.

"Vascularization, which determines the peripheral oxygen utilization in skeletal muscle and heart, is probably of major importance. The limiting factors, however, may be not only circulatory functions. In our series, the drop of F.F.F. (Flicker-Fusion-Frequency) after work was greater in the older men, despite the lower performance. The decreased endurance of older men, therefore, may be in part due to a decreased tolerance of the central nervous system, possibly resulting from the poorer cerebral circulation. The endocrine system seems to be involved in the decline of muscle strength and performance with age. Oral administration of methyl testosterone over a period of several weeks or months, in six men over 50 years, resulted in a significant increase in weight lifting and weight holding ability, and muscle strength. This was similar to the effect in four younger eunuchoids. In contrast, the treatment had no effect on four normal young men."

New Technics in the Diagnosis of Hyperparathyroidism, by JOSEPH W. GOLDZIEHER, M.D., San Antonio, *Geriatrics*, Volume 13, Number 8, August, 1958, p. 483.

This article is abstracted because of its compact and lucid presentation of a systemic pathologic entity frequently overlooked or not suspected. It well deserves the small space it requires.

"Hyperparathyroidism is a disease of middle age, outstanding for its vague clinical symptomatology. With earlier recognition mandatory, diagnosis must rely more and more on biochemical tests. Repeated determinations of serum calcium, phosphate, and total protein should be supplemented with studies of urinary calcium excretion on a low-calcium intake, of renal tubular reabsorption of phosphate, and of blood studies during a low-phosphate diet.

"The symptoms of longstanding hyperparathyroidism, occurring chiefly in middle-aged persons, may present a picture consisting only of such vague manifestations as weakness, nervousness, constipation, indefinite muscle pains, and minor urinary difficulties. On this basis, it has been suggested more than once that the routine physical examination of the middle-aged or elderly person should include a determination of the serum calcium."

Series of tests for the diagnosis of hyperparathyroidism, which are described in the text of the article

A. The Roentgenogram
B. Serum Calcium Determination
C. Serum Phosphate Determination
D. Tubular Reabsorption Phosphate Test
E. Intravenous Calcium Infusion Test
F. Calcium Excretion Test
G. Phosphate Deprivation Test

"The possibility of hyperparathyroidism must be kept in mind in all instances of vague 'neurotic' disorders without other explanation.

"The chemical changes may require numerous and repeated laboratory studies for their final elucidation. The determination of serum calcium and phosphate must in all instances be carried out repeatedly, with an awareness of their variability in this disease; the possible influence of the serum protein level must not be ignored. Evidence of the action of increased amounts of parathyroid hormone on the renal tubule may be sought by determination of the tubular reabsorption of phosphate. This is a simple, rapid test, valuable for its functional nature, but it is by no means pathognomonic.

"The loss of calcium and phosphate homeostasis in hyperparathyroidism may be demonstrated by calcium-deprivation or phosphate-deprivation technics, both relatively simple to perform and extremely informative. It seems almost trite to mention that clinical judgment, careful appraisal of the laboratory tests, and persistent diagnostic efforts may be necessary in those 'borderline' cases which are becoming evermore frequent as our *index of suspicion* continues to rise."

Insomnia in the Aged, by ZACHARY SAGAL, M.D., Sherman Oaks, California, *Geriatrics*, Volume 13, Number 7, July, 1958, p. 463.

"Aged people often complain of insomnia. While at times the complaint seems unjustified and factually incorrect, it is best to allow the old person the extra amount of sleep desired. Recent researches seem to indicate that sleep has a restorative function beyond that of a general nature.

"The prevailing notion that the older one gets the less sleep he needs may be incorrect and the opposite may be true with advancing age, the older person needs more sleep as the basis for good health and as a prophylactic against premature aging. The very concept of 'normal' and of 'premature' aging perhaps needs revision. Professor Braines reminds us of the theoretic researches of Metchnikoff, Bogomoletz, and Lasarelf, which led them to believe that a life span of 150 years can be eventually hoped for."

What Can Be Done For Insomnia?

"It has been my opinion for many years that

with advancing years less and less sleep is required for maintenance of normal health, I had many arguments with patients and friends to convince those who were not satisfied with five or six hours of sleep. The advice to just rest in bed if unable to sleep was rarely taken kindly.

"Lately I have come to agree with Dr. Alvarez who, on many occasions, has advocated the use of mild soporifics, for he is convinced of the innocuousness of their use over long periods. A colleague and classmate of mine has been taking routinely 3 gr. of Seconal® every night for many years without any ill effect, not even a morning hangover. On several occasions, his wife told me how she would lie awake at night and envy his deep sleep. She tried taking a small dose of a barbiturate, but it made her drowsy all the following day One must remember that there is an individual sensitivity to soporifics and that people react differently to them. Lately, I have come to the conclusion that there is no hard and fast rule to go by and each case must be treated individually."

A Look at Atomic Medicine in Geriatrics, by LEE E. FARR, M.D. (Medical Director, Brookhaven National Laboratory, Upton, Long Island, New York), *Journal of Gerontology*—Supplement No. 2, p. 27.

The following excerpts of this article have been abstracted rather generously. The reason for it is that the topic is most timely and the presentation is admirably impressive. It is indeed a gem of perfect presentation and compactness. If space had permitted, the temptation to lift the article *in toto* would not have been resisted. It is however, suggested that those interested should try to read the article in full.

"It is necessary that clear distinctions be made between diseases of older ages and the involutional changes of age itself. Bone composition changes regularly with time, and thus this alteration is a reflection of age, not disease. In other organ systems similar changes may and do occur with time. The present discussion is not addressed to efforts looking toward the postponement of phenomena of age. It must be clearly established that the assigned causes of death in the aged are to be constantly reevaluated since the recorded causes will be weighted for disease etiology favored by our medical habits and fashions, biased by our diagnostic systems, and profoundly influenced by our ignorance of many normal physiologic changes.

"Medical successes in overcoming the hazards of infectious diseases, in establishing the causes of and control of diseases resulting from dietary insufficiencies, avitaminoses, pernicious and iron deficiency anemias, in reducing the risk of surgery so that many disorders of middle-age can be met satisfactorily by removing the affected part and in providing adequate corrective therapy for some intrinsic diseases, such as diabetes mellitus, leads us to the hope that as we can define the abnormal changes occurring in older people, we may, by application of new techniques available to us, be able to bring a measure of control to these disease states.

"Since the onset of degenerative disease is insidious, because its causes as yet may be largely unknown, physicians are limited today to a few corrective measures of palliation. They cannot rehabilitate the disordered physiology much less can they stop its progression. This means that diagnosis is at best uncertain and difficult, treatment largely empirical, and limited by individual experience to an undue degree. If physicians are to gain better insight into these disorders and perhaps as well into the phenomena of aging, they must have at their command a method whereby they can scrutinize minutely the performance of an organ system, or perhaps under certain circumstances, the cellular components of the system. Until the last few years there were no means by which this could be done except indirectly and then by great effort at high cost.

"It is desirable that there be a method whereby literally one can peer into cells and observe the happenings therein. Fortunately, radioactive isotopes permit just that to be done. By the emission of gamma activity one can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externally follow movements through the body and by properly utilizing any form of radioactivity one can follow the sequence of synthesis and degradation that occurs in the normal utilization of foodstuffs to building of tissue and its ultimate replacement.

"With radioactive elements it is possible to introduce only a very minute amount of the material to be studied. Thereby no new factors of load are introduced which may of themselves alter the sequence of events. By choosing radioactive elements of different activities; that is, energy emissions of different half life, of different sequence of transformations, and of different particle emissions, one can bring to bear upon a single series of events a multiple type of examination.

"This approach now can be carried out in a wide variety of manners depending upon the selection and utilization of the isotope. The development of reactors and accelerators which can be used to manufacture radioisotopes in large quantity and even more important the development of detectors capable of revealing quantities of radioactive isotopes so small that the radiation is not of significance to the whole organism, now make studies of this kind practical.

"In biochemistry the widespread and rapidly growing use of radioactive isotopic labeling attests best of all to the usefulness of the procedure. If no alteration of the compound is a requisite, most organic compounds must be labeled either with radioactive carbon, or radioactive hydrogen, more commonly called tritium. While these labels are completely satisfactory within their own sphere of usefulness, neither has a gamma emission. Therefore, removal from the body, and in some instances, concentration may be required for analysis or detection. In other circumstances, however, it is possible to insert into the molecule a suitable gamma-emitting isotope such as iodine and thereby enable detection of the isotope by counters external to the body and observation of the isotope's movement within the body and its localization if such occurs.

"The role that trace metals may play in the metabolism of man is yet largely unknown. By means of radioactive isotopes, methods of study of metal behavior and occurrence not heretofore available can become almost routine. The further development and use of activation analysis will enable the investigator to analyze tissues for a galaxy of elements—the analysis being carried out without alteration or manipulation of the specimen and being effected simultaneously for all components using radiologic analysis to sort out the various components.

"These observational capabilities give promise of much new knowledge on the exact disturbances present in degenerative disease. With the use of radiation itself to produce degenerative disease analogs the possibilities are greatly enhanced. With such knowledge at hand, it is to be hoped that measures can be contrived which will control or alleviate these disorders. While the promise is great, as of this date performance is slight and much work remains to be done before the promise can slowly be fulfilled.

"In the field of neoplasia, looking only at the areas using radioactive isotopes, I need only mention the application of cobalt 60 teletherapy, intracavitary therapy with colloidal gold and colloidal phosphorous, and infiltrative tumor mass therapy with these same colloidal compounds as well as cobalt 60 needles.

"Finally, I should like at this point to alter this discussion to a very brief consideration of degenerative conditions of the skeletal system that may be, at least in part, caused by environmental changes. In this day and age, with the rapid development of atomic energy and its utilization in industrial endeavors as well as military efforts, it becomes necessary for each physician to acquaint himself with some of the physiologic effects of radiation and of tissue-deposited radioactive isotopes. It is a fact that we all are exposed to a small amount of radiation coming from fallout from weapon testing by ourselves, our friends, and those not so friendly to us. Therefore, physicians must be on the alert for disease disorders which may be caused,

exacerbated, or made manifest by small but significant depositions of radioactivity in organs such as the skeletal system.

"It is mandatory that physicians become conversant with expected signs and symptoms of radiologic exposure that in cases wherein radioactive elements are suspected as being a causative factor in the illness, the proper steps can be taken to verify the diagnosis and to follow this with appropriate therapy."

Venous Diseases in Older People, by J. EARLE ESTES, M.D., Rochester, Minnesota, *Geriatrics*, Volume 12, Number 5, May 1957, p. 284.

Malignant Neoplasm

"Recurrent episodes of thrombophlebitis, without apparent cause, frequently signal the presence of a malignant neoplasm."

Heart Disease

"Persons with organic heart disease severe enough to cause cardiac decompensation often have thrombophlebitis at some time during their chronic illness."

Chronic Occlusive Arterial Disease

"Ischemia from chronic occlusive arterial disease may result in leg ulcers which must be differentiated from stasis ulcers of chronic venous insufficiency. Furthermore, ischemia superimposed upon chronic venous insufficiency may have a pronounced deterrent effect upon healing of a stasis ulcer. Thus, it is important to determine whether chronic occlusive arterial disease is present in order to evaluate its effect on the clinical manifestations of chronic venous insufficiency.

"Arteriosclerosis obliterans is a common, easily diagnosed disease. The diagnostic criteria include such manifestations as claudication, subjective coldness of the lower extremities, ischemic neuropathy, ulceration, gangrene, reduced or absent peripheral arterial pulses, coldness and pallor of the affected extremities, calcification of arteries on roentgenography, and hyperlipemia."

Other Physical Factors

"The careless eating habits of many older people may lead to loss of weight and malnutrition. This in turn may complicate an existing state of chronic venous insufficiency by causing or increasing edema of the leg from hypoalbuminemia. Also, by interfering with normal tissue metabolism, malnutrition may retard the healing of an ulcer.

"Older persons have a higher incidence of thrombophlebitis and pulmonary embolism during the postoperative state than do younger persons.

"Many aged people become relatively inactive, sitting in a chair for prolonged periods.

"Older people are prone to minor injuries to their lower extremities because of poor eyesight, incoordination, weakness, falling, and decreased sensation in their legs."

Conclusions

"I should like to emphasize the extreme importance of one fact—namely, that the proper treatment of the primary venous diseases (varices and thrombophlebitis) prevents, almost without exception, the secondary manifestations of chronic venous insufficiency.

"The occurrence of manifestations of chronic venous insufficiency is a stigma of failure either on the part of the physician to institute proper prophylaxis for his patient or on the part of the patient to follow instructions."

Serum Cholesterol Levels Resulting from Various Egg Diets—Experimental Studies with Clinical Implications, by O. J. POLLAK, M.D., Ph.D., Kent General Hospital, Dover, Delaware, *Journal of the American Geriatrics Society*, Volume VI, No. 8, August, 1958, p. 614.

The problem of cholesterolemia, lipins, lipoproteins, what and where they derive from, their relationship to atherosclerosis and probably thrombosis are presently very much at the head of the discussions on cardiovascular diseases and cerebral vascular accidents. Confusion is more confounded by the many vague and in-

definite opinions and conclusions that continue to appear in the medical literature. The following few abstracts are presented, not with the intention of adding clarity to the situation but rather to prove the impossibility of it. The above titled article presents a research study on the effects of a diet consisting of one egg a day, raw, fried, boiled, or poached, given to several groups of rabbits, over a period of twenty-one days.

The results seem to indicate very definitely that such a diet raises the blood cholesterol levels markedly, to three and even five fold.

Following through the article the thought came that: "Here Goes The Bacon and Egg Breakfast." However, further discussion by the authors eases that fear.

"The experiment had several limitations. Though eggs were secured from a single supplier they differed in total weight, thickness of shell, volume and weight of egg white and yolk, the amount of cholesterol, and probably the amount of all the other constituents. The rabbits did not eat exactly the same quantities of egg or chow, nor did they eat at the same pace. All animals ate the egg dishes mixed with rabbit chow readily. They were especially eager to eat fried and scrambled eggs.

"It is impossible to apply the results of animal experiments to man. Rabbits, weighing 3½ pounds each, received, daily from 91 to 165 mg. of cholesterol (more correctly of Burchard-Liebermann-positive material) in the form of egg. A man weighing fifty times as much as the rabbit, i.e. 175 pounds, would have to ingest 4.5 to 8.25 gm. of cholesterol daily or about fifty eggs daily to obtain similar results. Rabbits of series XI ate 91 mg. once a week. Consumption of 4.5 gm. of cholesterol per week would not be unusually high for an adult man. However, a man would not consume all cholesterol in the form of fifty raw eggs on one day and then eat a cholesterol-free diet for six days. In rabbits, hypercholesterolemia after twenty-one days of a fried egg diet was 4.25 times higher than after a raw egg diet, and 3.5 times higher than after a soft boiled egg diet.

"Investigation of the effect of heating on the cholesterol content of various foodstuffs seems desirable. We may have to revise our diets for persons with a tendency toward hypercholesterolemia by paying as much attention to the preparation of the food as to the components of the diets."

Calories and Cholesterol, by ANCEL KEYS, Ph.D., Minneapolis, *Geriatrics*, Volume 12, Number 5, May, 1957, p. 301.

"Let us set the record straight at the outset. It is not insisted that the diet is the only factor in the production of coronary heart disease or even in the development of atherosclerosis.

"The thesis for consideration here is that the diet influences both atherogenesis and thrombogenesis and is an important part of the reason for the differences between populations in the age-specific frequency of coronary heart disease.

"We are concerned about the situation where we in America have three to five or ten times the coronary heart disease burden of many other populations.

"We have been able to find no consistency and no explanation for these differences in terms of race, climate, the use of alcohol and tobacco, urbanization, habitual physical activity, exposure to ultraviolet light, atmospheric smoke, gasoline fumes, and so on. Any one, or all, of these factors may have some influence but, if so, it is not yet apparent.

"Nor do we find any support for the idea that emotional stress is involved, if we take as indicators of the stress force such items as the hazards of street traffic, housing congestion, frequency of the use of telephones and of radios, indulgence in competitive business or sports, the burden of high taxation and bureaucratic governments, or presence of political and social strife in the community."

Population Samples

"Table 4* summarizes some of the results

* Tables 4 and 5 referred to in this abstract are not printed herewith.

from field studies on population samples. These extend to human lifetimes our necessarily brief, controlled, dietary experiments in the laboratory. This table covers only men aged 40 to 49 years and is representative of a total of 27 series of men of this age, all of whom fit equally well the relationship between diet fat and serum cholesterol concentration shown in these examples.

"All the evidence we can gather indicates that the general relationship shown here also holds for the incidence of coronary heart disease. If we took the coronary incidence in middle age among Minnesota firemen to be one hundred, the value for the Japanese miners would be less than ten. The corresponding value for the men in Malmo would average perhaps sixty."

Effects of Various Types of Fats

"It appears further that the cholesterol differences in these populations are not simply dependent on differences in the amount of linoleic or 'unsaturated' fats in the diet. Table 5 summarizes U.S. and the Japanese diets in regard to fats with, respectively, 40 and 12 per cent of total fat calories. The U. S. figures are calculated from the foods eaten in our national dietary average, checked by our local analysis. The Kyushu figures are computed from the sum of all the foods in the average diet at Shime as assembled by ten full-time dietitians in household surveys and measurements during April and May of last year.

"The U. S. diet provides almost twice as much linoleic acid as does the Japanese diet. The sum of linoleic plus other poly-ethenoic fatty acids is also greater, per calorie, in the U. S. diet. Most of the 'other poly-ethenoic' fatty acid in the Japanese diet is in fish oils. Fish oils have a very high iodine number but, as we have found in controlled experiments on man, fish oil has about the same effect on serum cholesterol as does cottonseed oil."

Hospital Findings

"I have pointed out that the mortality rate ascribed to coronary heart disease in different populations tends to follow the proportion of total fats in the local diet. A similar relationship between diet fat and coronary disease appear when we survey the hospitals of different populations. Further, it is instructive to examine the frequency of finding of severe—that is, grades 3 and 4 on a scale of 0 to 4—atherosclerosis in unselected autopsies in general hospitals in Japan, Hawaii, and Minnesota. Caucasians in Hawaii and men in Minnesota are substantially identical in the high frequency of atherosclerosis, and in both places the diet averages slightly over 40 per cent fat calories. The frequency of severe atherosclerosis in Kyushu, where the diet averages about 12 per cent fat calories, is roughly one-tenth as great at equal ages. And, in Hawaii, where the local Japanese diet averages about 30 per cent fat calories, the frequency of severe atherosclerosis is intermediate between the figures for men in Japan and men in Minnesota."

Fats and Coagulation Time

"After a carbohydrate meal of rice, sugar, and skimmed milk, or during continued fasting, the clotting time tends to increase slightly during the next six hours. But, after a meal with equal calories as butterfat, the clotting time tends to shorten and there is a state of relative hypercoagulability lasting from about an hour and a half to about six hours after the meal.

"Other things being equal, it is reasonable to expect that the frequency of coronary thrombosis, and of thromboembolic phenomena in general, should be higher in populations who frequently eat fatty meals than in those who do not. And this is precisely what seems to be the case.

"Finally, it should be mentioned that, within a number of populations, comparisons have been made between population segments differing, because of economic differences, in the proportion of fat in the diet. In each case, the serum cholesterol average and the frequency of coronary heart disease are considerably lower in the low-fat diet population segment. Israel, Guatemala, Italy, Cape Province, South Africa, and

Spain are examples of areas where such data are found."

Conclusions

"There is no reason to believe that the addition of corn oil, sunflower seed oil, safflower seed oil, or fish oils to our diets, without other diet changes, could prevent or control coronary heart disease.

"Lastly, it should be realized that we are far from knowing all the answers. We need a great deal more research. But I doubt that the day will come soon when we can load our blood with fat without affecting cholesterol and blood coagulability. I see no prospect of preventing coronary heart disease merely by taking pills or capsules or periodic swallows of corn oil."

The Problem of Atherosclerosis: A Brief Review, by JEROME M. WALDRON, M.D., *Geriatrics*, Volume 13, Number 5, May, 1958, p. 261.

"The term atherosclerosis has a different meaning in different papers. Some studies are concerned only with the problem of coronary occlusion, which may or may not be related to atherosclerosis. Nevertheless, patients with this condition are considered as part of the problem of atherosclerosis. The same approach is also used in reports on cerebrovascular accidents and in peripheral vascular disease.

"Another error is the use of the term atherosclerosis for an acute episode in place of the chronic process. Again, this is evident in reports on coronary occlusion. Nonfatal myocardial infarction cannot be unequivocally classed as coronary atherosclerosis; it may be the result of thrombosis in an area where there is no atherosclerosis. In addition, the conditions which produce acute episodes in an atherosclerotic vessel may have no relation to the condition producing the chronic process of atherosclerosis."

Diet and Atherosclerosis

"The most popular concept today is that atherosclerosis is primarily related to diet. This is based on (1) the correlation of a high serum cholesterol in most patients with atherosclerosis; (2) the experimental production of atherosclerosis in animals by feeding cholesterol; (3) the fatty character and cholesterol content of the atherosclerotic lesions; and (4) epidemiologic studies of correlation of coronary artery disease and diet. Acceptance of each of these relationships builds a good case for diet as a cause of atherosclerosis, but each observation is open to serious objection."

Relationship of Foodstuffs

"Perhaps a deficiency of carbohydrates rather than excess of fat is the important factor. Because of the preoccupation with fat, this facet is not discussed or investigated. Another problem along the same line is the effect on the metabolism of one foodstuff or another.

"They are often based on formula feedings or such restricted diets as to be impractical. It has never been shown that the low-fat or low-cholesterol diet has made anyone live any longer; it just makes it seem longer."

Evaluation of Treatment

"The only possible means of preventing atherosclerosis is in the treatment or prevention of diseases which are known to accelerate the process. Diabetes and hypothyroidism are the most common diseases associated with increased atherosclerotic process, therefore, the treatment of hypertension also becomes an important step in preventive medicine.

"Although this report has taken a rather negative approach to the treatment of atherosclerosis, it is done in an effort to clear the air. For too long, too many have talked as if atherosclerosis were understood. Much is known and there are many interesting leads, but much more research is needed to reach clear understanding and definite form of therapy."

Coronary Heart Disease, by WILLIAM LIKOFF, M.D., Philadelphia. William Likoff is associate professor of internal medicine, The Hahnemann Medical College. *Geriatrics*, Volume 13, Number 5, May, 1958, p. 266.

Discussion

"This study indicates that a myocardial infarction seldom occurs for the first time in a patient who is 70 years or older unless there has been significant prior evidence of coronary heart disease. Discounting the nonspecific roentgenographic evidence of minimal left ventricular enlargement, discrete indications of a pre-existing cardiac disorder were demonstrable in all but two of the thirty patients reported.

"This contrasts with the recorded experiences in younger individuals. In the majority of patients under forty, myocardial infarction occurs without antecedent clinical manifestations. Indeed, sudden death may be the initial indication of unusual coronary atherosclerosis. Similarly, in many persons between forty and sixty an infarction can develop quite unexpectedly.

"Although clinical manifestations of coronary atherosclerosis generally are present in the aged persons who are seriously afflicted with the condition, positive objective findings are more common and dependable than historical or subjective data. For example, only one of five patients in this study had angina pectoris immediately before the infarction as opposed to the four of every five patients who had an abnormal electrocardiogram. Furthermore, the atypical features of the angina pectoris in many instances reduced the importance of the syndrome as a diagnostic aid. This also is in contrast with events in younger patients in whom subjective complaints frequently antedate, and almost invariably complement, objective abnormalities.

"Three facts point up the seriousness of an infarction in the aged. The immediate mortality in the group observed in this study compares poorly with experiences among younger patients suffering their first infarction in whom a rate as low as eight per cent may be expected. Furthermore, one of every two patients experienced severe heart failure at the time of the infarction or during a reasonable period thereafter. Finally, approximately forty per cent of those who recovered failed to survive two years.

"As noted, the majority of the patients in this series had significant pre-existing coronary atherosclerosis. Purportedly the collateral coronary bed increases in response to the degree of this vascular impairment. However, from the mortality and morbidity statistics reported, the collateral coronary circulation was not adequate enough to counterbalance the impact of an acute myocardial infarction. Furthermore, it did not prevent an unusually high percentage of transmural involvement. Of course, it is not reasonable to suggest on this basis that pre-existing coronary atherosclerosis does not augment the growth of a collateral coronary circulation. However, it is more logical to suspect that the rigors and deteriorations of age, when combined with an acute disease process, often undermine what under more ordinary physiologic circumstances would have been a satisfactory compensatory mechanism."

2404 Eutaw Place
Baltimore 17, Maryland

SURGICAL MEETING IN CHARLESTON

All members of the medical profession are invited to attend a three-day Sectional Meeting of the American College of Surgeons in Charleston, South Carolina, January 19–21, 1959.

The program will include discussions on arterial occlusive disease, abdominal emergencies, management of gastrointestinal hemorrhage, trauma, cancer, common duct strictures, massive hemoptysis, acute hand injury reconstruction, cholecystitis, and many more topics of current concern. An exceptional program of medical motion pictures will also be shown.

THE PHYSICIAN'S ROLE IN THE SOCIAL SECURITY DISABILITY PROGRAM[1]

MAURICE D. DEWBERRY[2]

Doctors, hospitals, institutions, and agencies who have contact with disabled people are frequently asked these days to fill out medical reports in connection with claims under the disability provisions of the Social Security law. These provisions protect severely disabled people in three ways:

1. Benefits are provided for insured workers age 50–64 who are no longer able to work because of an extended total disability. Beginning September 1958, benefits may also be paid to certain of the disabled workers' dependents—namely, wives and dependent husbands who have reached retirement age, unmarried dependent children (including sons or daughters disabled in childhood), and wives who have a child entitled to benefits in their care.
2. Benefits can be paid to adult disabled sons and daughters of retired workers and of workers who have died. To be eligible for these benefits, the disabled son or daughter must have a disability which began before age 18 and has continued uninterruptedly.
3. Disabled workers, regardless of age, can "freeze" their social security records to protect their own and their families' future benefit rights.

To qualify under these disability provisions, a person must be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration. A disabled worker must, in addition, have social security credits for work in at least 5 out of the 10 years before he became disabled and must be fully insured. The social security credits needed for a fully insured status may vary from person to person depending on age. Five years of work under social security will be enough to meet the "fully insured" requirement through 1960. Anyone with 10 years of social security credits is fully insured for life.

Benefits are not payable for the first six months that a person is disabled. However, as in the case of the old-age insurance benefits, the law protects a person who delays filing his application for sometime after he meets the requirements for payment (including the six-month waiting period), in that it permits back payments for as much as 12 months.

All applicants, whether for benefits or for the freeze, are referred to their State vocational rehabilitation services. Payments to the disabled worker and his eligible dependents are suspended if the disabled worker refuses, without good cause, to accept available rehabilitation services. On the other hand, if the disabled worker accepts the rehabilitation services and performs work pursuant to an approved State vocational rehabilitation program, benefits may continue for as much as 12 months after he starts that work.

Workers with long-standing disabilities have until June 30, 1961, to apply to have their social security records frozen as of the time they actually became disabled. In some cases this may go as far back as October 1941, the first date when the work requirements could have been met.

Under the social security law the benefits payable to a child ordinarily stop at age 18. Where a disabled child was entitled to benefits before age 18, his benefits will be continued so long as he is disabled. Otherwise, his benefits begin when the parent on whom he is dependent

[1] This article is a result of recommendations submitted at the 160th annual meeting by the Medical Advisory Committee to Bureau of Old Age and Survivors Insurance to promote mutual understanding between local administrative agencies and the medical profession.

[2] Regional Representative, Bureau of Old-Age and Survivors Insurance.

becomes entitled to disability benefits (age 50–64) or to old-age insurance benefits, or dies, regardless of the child's age at that time. In contrast to the benefit or "freeze" applicant, the disabled child does not need a record of work under social security. The disabled child must, however, meet the same definition of disability as disabled workers. The mother of the person receiving this type of benefit may qualify for mother's benefits if she has the disabled son or daughter in her care.

Applications under the social security disability provisions are taken by the social security district offices, located in Baltimore, Cumberland, Hagerstown, Silver Spring, and Salisbury, Maryland. The social security district office gives the disabled applicant information about his rights, helps him to fill out his application, and to get the proofs and documents he may need to support that application. Under the law, the disabled person is responsible for furnishing, at his own expense, the evidence to show that he is "disabled" within the meaning of the social security law.

His social security district office gives him one or more copies of a medical report form on which this evidence can be supplied. He is asked to take or mail this form to his attending physician or to a hospital, institution, public or private agency where he has been treated for his disabling condition. This report form, designed as a guide for the reporting physician, lists the kind of medical facts essential for the determination of "disability." However, the reporting doctor is not required to use it; if he prefers, he may make his report in the form of a narrative summary or he may submit photocopies of the pertinent medical records. The completed reports are to be returned by mail to the social security district office.

By providing a full and objective clinical picture of his patient, the reporting doctor fulfills his responsibility to his patient, and incidentally, expedites the decision. To be of maximum use for the evaluation of a patient's capacity for work, the report should include a history of the impairment, the symptomatology, clinical findings and diagnosis. It should be noted that the attending physician is asked only to provide this type of objective medical data. *He is not put in the position of having to decide the issue of "disability."* The determination as to whether a patient is "disabled" must be made within the scope of the social security law; often it is based on evidence from more than one medical source. Also the determination must take into account factors which are not purely medical—factors such as education, training and work experience.

After the applicant has filed his claim under the disability provisions, and furnished the supporting evidence, his case is forwarded by his social security district office to the State vocational rehabilitation agency. Under the agreement between the State and the Federal Government, the State agency makes the disability determinations for its own residents.

The evaluation of disability is made by a "review team" in the State agency. There are at least two professional people on each team. One of the two is a doctor of medicine; the other is trained in evaluating the personal and vocational aspects of disability. The team must decide whether the applicant is sufficiently disabled to prevent him from engaging in any substantial gainful activity within the foreseeable future.

In many cases it is necessary to write back to the reporting physician because the medical report does not contain enough clinical facts. As a rule, the kinds of medical facts that the attending physician needs in making his diagnosis and in treating his patient are the same as those required to evaluate the severity of impairments in disability programs. However, certain medical facts are more highly significant in disability evaluation than to medical management of the case. To evaluate the effect of the impairment on the individual's ability to work requires the kind of medical evidence that confirms the diagnosis and measures remaining functional capacities of mind and body. By furnishing complete and objective evidence, the reporting physician makes

it unnecessary for the reviewing physician to "write back" for additional clinical or laboratory data.

Where the medical evidence initially submitted indicates a reasonable likelihood that the applicant is disabled, but more precise clinical or laboratory findings are needed to arrive at a sound decision, or to resolve conflicts in the evidence, a consultative examination (usually at the specialist level) may be ordered to obtain additional information. Selection of consulting physicians and payment of fees are governed by State practices.

Some doctors feel that they should be reimbursed by the Government for the cost of preparing the medical reports on their patients, and it is, of course, quite within their prerogative to charge the patient a fee for that service. However, under the law, the Social Security Administration cannot pay that fee; that is the individual's responsibility.

Other doctors are perturbed when asked to complete medical reports for individuals whom they may not have seen for years. In these cases, however, the physician is not expected to describe the present condition of the patient, but his medical condition as of the time he made his last examination.

Evaluation of Disability

The central purpose of disability evaluation is to determine remaining mental and physical capacities. To determine: (1) what the claimant has left, and (2) what he can do with what he has left.

A realistic evaluation of disability must be based on clinical and laboratory tests of the individual's ability to meet the metabolic demands of activity, to reason, to perceive, and to perform certain basic activities such as sitting, standing, bending, and walking. When incapacity results from severe impairment of one or more such functions, it is essential to establish not only the fact that functional impairment exists, but also its extent.

A brief discussion of disability from heart disease may serve to illustrate the kind of evidence needed to measure the patient's remaining functional capacity, after appropriate therapy. Most frequently, impairments of the circulatory system produce loss of bodily function by reduction of cardiac reserve, or interference with peripheral vascular circulation. As a result the circulatory apparatus cannot meet effectively the metabolic demands placed upon it. The diagnosis of the condition usually reflects whether the impairment is caused by valvular disease, myocardial damage or vascular pathology.

Cardiac size by X-ray or physical and EKG findings furnish objective proof of cardiac pathology. The amount of dyspnea or angina described in terms of the number of steps that can be mounted or distance in feet or blocks that the patient can walk is highly significant to evaluation of the degree of loss of function. The presence or absence of cardiac edema and response to therapy are also indicative of severity of cardiovascular impairments. The status of the pulse in the peripheral vessels may provide gross clinical evidence of impaired circulation of the extremities.

Impairments of the cardiovascular system may manifest themselves with dramatic suddenness; e.g., myocardial infarction, obstruction of vessels in peripheral or central nervous system circulation, lungs, and other visceral organs. The initial clinical manifestations are severe and the prognosis dubious. With survival from the acute stage, and appropriate therapy, substantial improvement can be expected over a period of time. A realistic evaluation of remaining function should be made after the convalescent period. Hence, the clinical and laboratory findings after maximum improvement from treatment are particularly valuable in making a determination of remaining cardiac, brain, or other function. (Note that a "waiting period," is prescribed by law, i.e., the first monthly disability insurance benefit cannot be paid until the seventh month after the onset of the disability.) A description of the acute attack helps confirm the diagnosis and should therefore be included in the report.

Loss of function is evaluated on the basis of clinical and laboratory findings after maximum benefit from treatment. Clinical information con-

cerning nature and response to treatment furnishes information on stability of functional capacity; i.e., a history of periodic decompensated heart disease, in spite of treatment, would indicate a comparatively severe condition.

More complicated tests of vascular function may be required in certain cases; e.g., arteriography. The reporting physician should not be concerned because he may not have equipment to perform these tests. A carefully performed exercise tolerance test (if not medically contraindicated) will almost always provide the clinical evidence needed to evaluate the degree of remaining function.

SUMMARY

In developing evaluation guides for the use of State agencies and its own technical and professional personnel, the Social Security Administration has had the continuing cooperation of a Medical Advisory Committee composed of recognized specialists associated with medical and allied professions in various fields outside Government, such as general practice, research, medical education, industry and labor.

The American Medical Association has taken steps to inform its members about the medical aspects of the disability program, especially the preparation of medical reports. On June 1, 1957, the Journal of the American Medical Association carried a comprehensive report on the administration and organization of the disability provisions. Regulations on the meaning of disability appeared in the September 28, 1957, issue.

700 East Jefferson Street
Charlottesville, Virginia

REMINDER REGARDING RESOLUTIONS!

Important Notice for Component Medical Societies and Individual Members of Medical and Chirurgical Faculty

The House of Delegates of the Medical and Chirurgical Faculty approved the following recommendations concerning the procedure to govern the reports which are given at the Annual and Semiannual Meetings:

1. All reports must be sent to the Faculty office. Those reports which contain recommendations or resolutions must be in the office eight (8) weeks prior to the Annual or Semiannual Meeting, whichever happens to be concerned.

2. When the reports are received, those containing recommendations or resolutions will be sent to the Component Societies for consideration so that the Component Delegates may be instructed if desired. These reports will also be referred to Council for discussion at its meeting prior to Annual or Semiannual Meeting.

3. Those reports which contain resolutions are to be referred to the Resolutions Committee for consideration.

4. The Council will refer to the Resolutions Committee any recommendations which it feels should be formulated as resolutions. The Council will also transmit to the Resolutions Committee an opinion of the policy involved in the Resolution.

5. Reports will be presented to the House of Delegates as usual, and it will be suggested as is normally done that reports not containing recommendations or resolutions be accepted as printed and distributed.

6. Those reports containing recommendations or resolutions will be considered and acted upon individually by the House of Delegates.

This policy will be followed in all future meetings.

AS A RESULT OF THIS ACTION OF THE HOUSE OF DELEGATES, RESOLUTIONS FOR PRESENTATION TO THE APRIL, 1959 ANNUAL MEETING OF THE HOUSE OF DELEGATES, MUST BE IN THE HANDS OF THE SECRETARY, DR. WILLIAM CARL EBELING, AT THE FACULTY OFFICE, BY FEBRUARY 18, 1959.

As adopted by the Council, the members of the Medical and Chirurgical Faculty are advised that the Resolutions Committee is anxious to hear expressions of opinions from members on any resolutions being presented to the House of Delegates at either the Semiannual or Annual Meetings, and that members in good standing who might wish to appear before this Committee to discuss a pending resolution may do so upon making a request to that effect to the Resolutions Committee.

TEACHING OF GERIATRICS IN THE SCHOOL OF MEDICINE, UNIVERSITY OF MARYLAND*

HERMAN SEIDEL, M.D.

According to Dr. Woodward, medicine, including the various phases of geriatric elements, is taught to the student body as early as the second year. This is accomplished by means of various group discussions arranged for the first and second year students, at which disease is studied from the point of view of general medicine, social problems and genetic considerations. In these studies the effect of disease is genetically traced through the various body organs, observing their sensitivity to disease and their resistance to infection and wear and tear during the life span of the individual. These studies and discussions offer many opportunities to the student to gain real insight into the aging process.

This all-inclusive method of teaching is applied in the hospital wards, out-patient department, medical care department and chronic illness hospitals during the subsequent years of the student's study at the School of Medicine. In all the various clinics and departments the medical student is abundantly exposed to health problems of the individual in his younger and more advanced years.

The older patient predominates in the above clinics because of the steady increase of the number of the aged in the community and because the older person is subject to many ailments that accompany the advancing years, such as cardiovascular ailments, malignant disease and hormone deficiencies.

Here the medical student has numerous opportunities to meet with the many variations of the above ailments, their final stages, as well as their beginnings. Thus the student learns the sequence of the evolutionary stages of the degenerative disease and is able to trace them back to the etiologic causes, endogenous or exogenous, toxic or metabolic, hormone or psychological. The faculty endeavors to develop a positive approach by the medical student to the ailments that afflict the older person. He is taught to treat the patient's disease, not his years.

To give the medical student a clear insight into the environmental factors involved in many of the prolonged ailments of the aged, the student is delegated to follow his patient into the home so he can study the environment in which the person lives and to what extent it may affect the patient's home status and his ability to cope with his disabilities.

Dr. Woodward feels that the Medical School of the University of Maryland is striving for and developing a quality of teaching that is all-embracing and provides the student with the *basic knowledge*, with the *clinical experience*, and acquaintance with the environment in which the patient lives. This gives the student a full picture of the human being in his care and his ailments.

Medicine is regarded as one entity, not splintered into many specialties and sections. Dr. Woodward feels that over-specialization should be avoided and that the medical student should be taught to comprehend the broad range of medicine as an art and as a science. This means he does not feel that there should be established a separate department for the teaching of geriatrics as a specialized subject. He believes that the School should continue to strive, as it does, to provide the student body with facilities to study all of medicine including the various phases as they are affected by the individual's advancing years. But the study of these variations does not call for relegation of the older patient into a special department.

* Dr. Herman Seidel, Chariman of the State and City Committees on Geriatrics, discussed the problem of teaching geriatrics with Dr. Theodore E. Woodward, Professor and Head of the Department of Medicine, School of Medicine, University of Maryland.

RECOMMENDED BOOKS ON GERIATRICS

1. "The Care of the Aged" by Cowdry. Published by C. V. Mosby, 6th Edition.

2. "The Care of the Aged" by Thewlis. Published by C. V. Mosby.

3. "Diseases in Old Age" by Robert T. Monroe, Harvard.

4. "Geriatric Medicine" by J. Stieglitz. Published by C. V. Mosby, 3rd Edition.

5. "Psychological Aspects of Aging". Proceedings of a Conference on Planning Research, Bethesda, Maryland, April 24–27, 1955, John E. Anderson, Editor. Published by American Psychological Association, Inc., 1333 Sixteenth Street, N.W., Washington, D. C.

6. "Mental Disorders in Later Life" Edited by Oscar J. Kaplan. Second Edition. Published by Stanford University Press, Stanford, California.

7. "The Medical Care of the Aged and Chronically Ill" by Freddy Homburger, M.D. Published by Little, Brown and Company, Boston and Toronto.

8. "Aging-General Aspects" Ciba Foundation. Published by Little, Brown and Company, Boston, 1955.

9. "Modern Trends in Geriatrics" Edited by William Hobson. Published by Paul B. Hoeber, Inc., New York, 1957.

10. "The New Frontiers of Aging" Edited by Wilma Donahue and Clark Tibbitts. Published by The University of Michigan Press, Ann Arbor, 1957.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

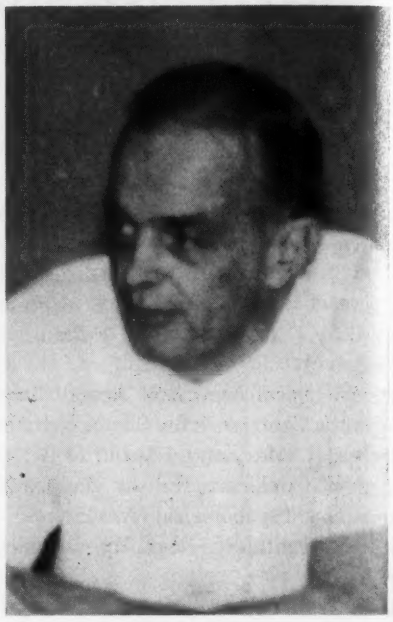
Dr. Faw Heads Hospital Staff

At a recent meeting of the Staff of Memorial Hospital, in Cumberland, new officers elected to serve for the year-1959 are:

President: Dr. Wylie M. Faw, Jr.

Vice-president: Dr. Samuel M. Jacobson

Sec'y-Treasurer: Dr. Frank T. Cawley



Dr. Wylie M. Faw, Jr.

Fifty Years Ago

Dr. John Frederick Charles Hadel was born in Hamburg, Germany in 1818 and died in Cumberland, October 14, 1885. His earlier life in Germany is mostly unknown, but he was a popular physician and gentleman. He had been a Baltimore City Health Officer.

Dr. Hadel came to America in 1845. He was of striking appearance and had two young sons, six and eight years old at his death. The doctor had been a Brigadier General in the German army. He was one of the victims of a double murder, apparently for the purpose of obtaining money by robbery.

The other victim was a man named Henry Graf. Mr. Graf also was a young German and a medical student in the office of Dr. Hadel, as was the custom in those days.

It was believed that Dr. Hadel always carried on his person a considerable sum of money and, with a view to securing it, another German by the name of Frederic Miller, induced him to make a supposed call about four miles west from Cumberland on the Braddock Road. Miller shot Dr. Hadel in the back with a heavily loaded shotgun. The doctor died within a few minutes and the murderer stripped his body, hid his clothes under the floor of a schoolhouse nearby and then proceeded to cut the head from the body. He hid the head beneath some rocks and dragged the mutilated body into the woods and concealed it among the bushes. He then returned to the doctor's office, evidently intending to rob it also. Finding Henry Graf, the young German medical student in the office, he induced Graf to accompany him to the scene of the crime late that afternoon. Near the scene of the first crime, he shot Henry Graf, dragged the body also into the bushes and covered it with stone. He then returned to the doctor's office where he robbed it of jewelry, clothing, books, medicine etc. and removed all of these to his boarding house on North Mechanic Street.

Four months later, the murderer was hanged; ironically by Dr. John Everett, who was then the Sheriff of Allegany County. When the murderer was caught, he was wearing the diamond shirt studs of Dr. Hadel.

Cumberland's First Military Hospitals

Early in 1862, the War Department established many hospitals in and around Cumberland for the reception of sick and wounded from points in the east and to the west. By February 1862, there had been fifty-seven deaths, mostly soldiers from Ohio and Indiana. Dr. Charles H. Ohr was then Mayor of Cumberland. The Second Maryland Regiment Vol-

unteer Infantry, under the name of the Potomac Home Brigade, had been organized the previous October. Dr. Samuel P. Smith was the surgeon, while Dr. Patrick A. Healey was the assistant surgeon. Both were from Cumberland.

Six months before, the Baltimore and Ohio Railroad and the Chesapeake and Ohio Canal leading from the east to Cumberland had been destroyed by the Confederate army and Cumberland was isolated. The railroad ceased operations for nearly a year. President Lincoln issued a call for three hundred thousand troops and Doctors Charles H. Ohr and Samuel P. Smith were members of a war mass meeting which submitted a resolution declaring it to be the duty of the people to maintain the government and requesting the County Commissioners to allocate fifty thousand dollars to be applied to the payment of bounties to volunteers. Thus, soldiers from the Cumberland area were paid to serve in the army.

By the first of October, 1862, the hospitals which had been established at Clarysville six miles west of Cumberland, were transferred to Cumberland under the direction of Dr. George H. Oliver, regular Union Army Medical Director. The old Belvedere Hall, the old Presbyterian Church and the Old Mill on South Mechanic Street were among the buildings taken over for hospital purposes.

On April 1, 1861, Dr. Charles H. Ohr had been appointed examining surgeon for those trying to enlist in the Union army. The State of Maryland had not yet made up its mind whether it was in favor of the Union, or in favor of the seceding Confederate States.

Previously, a mounted guard of twenty-eight men representing the Cumberland Continentals had crossed the Potomac River and thirty miles south in West Virginia prepared to take a stand against a Confederate force which was approaching Cumberland from the South. On encountering the Confederate force, the Cumberland command retreated over the mountains and reached Cumberland by way of the National Road. This was the initial conflict in the War between the States in this section.

The Federal War Department ordered the evacuation of Cumberland and all Union forces were to concentrate at New Creek thirty miles south of Cumberland over the Potomac River. Thus, Cumberland was wholly unprotected. Later, Cumberland was to be attacked on the east and every man, woman and child possible, armed with everything from broomsticks to guns, took off to the east to meet the enemy which was approaching from Baltimore north of the Potomac River.

In a few hours, the citizens of Cumberland took refuge in flight, but later returned to Cumberland. Shortly thereafter officers of the Confederacy rode into town to meet a deputation of citizens from Cumberland to be told that it would surrender. It was the understanding that private property was to be respected and no depredations would be permitted. Thus, Cumberland fell to the Confederacy on the 16th of May, 1863. The Mayor of Cumberland surrendered the city to the Confederacy, which caused many young men to join the cause of the South. Cumberland was cut off from communication in any direction. Shortly thereafter, Cumberland was occupied by Union troops and this nullified the surrender.

By November 4, 1863, Dr. Charles H. Ohr had been elected State Senator. Dr. Ohr at that time was Mayor of Cumberland. At the end of July, 1864, Cumberland was again threatened by the Confederates and Mayor Ohr made a speech urging the immediate formation of companies of citizens to defend the town. Cumberland was again attacked from the east and at Folck's Mill, three miles east of Cumberland, the Confederates and the defenders of Cumberland met arm to arm. The battle ended about dark and the Confederates moved toward the south, crossing the Potomac River at Greenspring, West Virginia.

Next May, 1864, Dr. John J. Bruce was elected a member of the City Council. In the early summer of 1865, Cumberland was designated as one of the places where United States troops would be mustered out of the service and three miles west of Cumberland, on the National Road, a camp was established by the Fifth United States Cavalry.

Ironically, Cumberland's newspaper *The Alleganian* had early declared itself in favor of the Confederacy. Union Grove, the site of the Camp in the Narrows just west of Cumberland, became a city overnight; with the grounds handsomely ornamented with arches, and bridges and lighted at night by means of large oil lamps. Throughout the war, Dr. Samuel P. Smith who owned the large hotel at the southeast corner of Mechanic and Baltimore Streets, leased it to the Federal Government for use as a hospital.

By the close of 1865, the last of the troops had departed from Cumberland and the military hospitals were abandoned.

PERSONALS

Dr. Richard Jones Williams, of Cumberland and Dr. William Oliver McLane of Frostburg, have been appointed Assistant Medical Examiners to Dr. Benedict Skitarelic, Deputy Medical Examiner of Allegany County.

Miss Elizabeth Ann Murray, student nurse at Memorial Hospital, Cumberland and daughter of Dr. Francis Alan Murray, has returned from Germany as a member of the All-American Chorus which broadcast at Radio Free Europe studio, in Munich, Germany.

Dr. and Mrs. S. G. Weisman, Cumberland, have just returned from a several weeks' tour of the European continent.

Dr. Ruth Peachey, formerly of Grantsville, heads a group which plans to build a medical clinic at Accident to house two physicians, a dentist and a pharmacist.

Doctors Hilda Jane Walters, Frostburg; Fuller B. Whitworth, Abraham J. Mirkin, Howard L. Tolson and Leslie E. Daugherty, of Cumberland, attended the Semi-Annual Meeting of the Medical and Chirurgical Faculty held at Ocean City, on September 12th.

Dr. Ralph W. Ballin, has been appointed to membership on the Cumberland Board of Health.

Announcement was made that Dr. William W. Lesh, of Pennsylvania, will be associated with Dr. Paul R. Wilson at Piedmont, W. Va., which is just across the river from Westernport, Maryland.

Dr. Leland B. Ransom, Cumberland, is instructor of a class in short wave radio communication at the Civil Defense Center.

Dr. Calvin Hadidian, doubling in the annual Allegany County Tennis Tournament, was declared co-champion. Dr. Hadidian and Mrs. Elly VanStrien won the mixed doubles crown. Mrs. VanStrien, is the wife of Dr. Ton VanStrien, City and County Health Officer.

Dr. James G. Stegmaier, Cumberland, has returned from a "Moose Hunt" in the province of Ontario, Canada.

At a recent meeting of the Academy of Psychosomatic Medicine in New York, Dr. Irving Baumgartner, of Oakland took part in a panel discussion titled "Goals of the Family Physician".

Dr. Charles Conrad Zimmermann has closed his office and temporarily retired from practice in Cumberland. Dr. Zimmermann intends to spend a great deal of time at his cottage on Deep Creek Lake, in Garrett County.

* * *

The beginning of all things is small

— Cicero

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

PHILIP BRISCOE, M.D.

Journal Representative

The Anne Arundel County Medical Society held a dinner meeting June 18, 1958, at Carvel Hall in Annapolis. Dr. Jack Handelsman, associate professor of surgery at the Johns Hopkins Medical School gave an informative talk on intestinal obstruction.

New members elected to the society included: Dr. James I. Hudson, Jr. who will practice pediatrics in Edgewater; Dr. Wilber A. Hammon, Jr. and Dr. Hildegard A. Reissman, both attached to the Crownsville State Hospital; and Dr. Febus Grunberg who will practice in Odenton.

The third dinner meeting of the year was held at Carvel Hall on Sept. 19, 1958. On this occasion Dr. Harold Stevens, Professor of Neurology at the George Washington School of Medicine, discussed unusual types of epilepsy as seen in practice. This meeting was well attended and included as guests, eleven medical officers from the Severn River Naval Command.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

On Tuesday, September 16, the Excutive Board of the Baltimore City Medical Society met to begin the current program year. First on the agenda was a letter concerning the possibility that the Baltimore City Hospitals might be building a private patient pavilion. This was felt to be unusual, at least, in regard to the purposes and best function of the City Hospitals. After careful discussion, President Firor appointed Dr. John T. King, Jr., chairman of a

committee to investigate the rumor. Drs. Otto Brantigan, J. Holmes Boyd, Walter Graham, and Donald Hebb were designated to serve on the committee with him. The encroachments of endowed institutions on the private practice of medicine have been viewed with alarm by the City Society for many years. That a tax-supported institution should enlarge to practice private medicine in competition with tax-payers who support it seems to be going too far, no matter how much the paid, "full time" staff may want to have a private practice, as well as a salary.

A letter from Dr. Peter Safar requested that the Committee on Principles and Techniques for Resuscitation be made a permanent committee of the Baltimore City Medical Society. The feeling of the Executive Board was that this Committee had done a good job, but that the Constitution limited the number of permanent standing committees. It was felt that an amendment to the Constitution would be required. It was unanimoulsy agreed that the Committee on Principles and Techniques of Resuscitation should be considered a special committee that should continue indefinitely until its job had been completed by giving demonstrations and training to those who applied, such as Red Cross instructors, ambulance attendants, and accident room physicians.

A City Society-sponsored bill collection service has been under discussion in the Executive Board for some months. The number of grievances that come to the attention of the Board has prompted the inquiry. The Board feels that unscrupulous methods used by many commercial collection services are not in the best interests of medical practice. The public relations effect of ethical collections cannot be overestimated, according to Dr. Kimberly, treasurer. Other medical organizations, county and city, have found it to their advantage, and a valuable adjunct, to have a central collection agency that can be controlled in an ethical manner. To start such a collection service, an institution with a relatively large amount of delinquent accounts would be needed. Inquiries have been made at various hospitals. One or two of these hospitals when approached seemed quite willing to go along and turn their accounts over to such an agency for collection. If sufficient support is elicited, a collection service, under the auspices of the City Medical Society, probably will be initiated.

The idea that the Baltimore City Medical Society should put out its own Monthly Bulletin was put forward by John Sargeant, executive secretary of the State Medical Society. A question was raised immediately as to whether it would conflict with the Maryland State Medical Journal. There seemed to be some question as to whether we would need to add to our paid secretarial staff to start such a bulletin. It was indicated that some revenue from advertising could be expected, which might in time more than pay for such a bulletin. The chief reason for wanting such a bulletin for the City Society's very own would be to get announcements out promptly to the members, with a list of all meetings. It has been felt that three months' delay between deadline and mailing makes the State Journal out of date before it is published. The problem was referred to the Committee on Public Medical Education, Dr. Hanford Hopkins, Chairman.

A physician wrote to inquire whether it is ethical to insert an announcement in a local community newspaper regarding the opening of an office for the practice of medicine. He pointed out that in some communities this is a customary practice. In other communities it is considered solicitation and is frowned upon. The State law is very strict as to the amount of "advertising" a physician may do. Even the dimensions of his shingle are prescribed. It was felt that the physician should conform to the local customs. A factual statement that his office had been opened was not considered out of bounds, but anything that seemed to suggest solicitation was beyond the pale.

The Board then discussed the best ways to communicate its activities to the membership through the Section chairmen. It was decided to invite the Chairmen of Sections to attend the October meeting of the Executive Board. The question of having them attend them regularly, or be members, seemed to be another matter. The Board feels that the Chairmen of the Sections are not elected by the whole Society and should not act for the whole Society. Too many present would be unwieldy, and the delicate matter of grievances must be handled in the strictest of privacy, members of the Board being pledged not to reveal the nature of grievances in any way, even to their own wives. The mailing of the agenda of the Executive Board meetings to the general membership and/or the officers of the Sections was considered, so that people who wished to be present could come for matters of interest.

Dr. Kimberly, treasurer, reminded the Executive Board that the coming Woman's Auxiliary "Red Slipper Ball" was to raise funds for its charitable purposes, and would this year replace the December meeting which they usually have with the doctors. The Board enthusiastically endorsed the idea and promised to support it.

* * *

On Friday, October 3, the Baltimore City Medical Society inaugurated its 1958-59 winter season with a most interesting program, sponsored jointly by the Radiological and Orthopedic Sections, of which Dr. Nathan B. Hyman and Dr. Edmond J. McDonald are respective chairmen.

Prior to the scientific section, 51 active and 95 associate members were elected. An insurance plan was presented. The low rates and conservative attitude of the insurance company were emphasized.

Dr. McDonald, Chairman of the Orthopedic Section, introduced Dr. Lent C. Johnson, Jr., Director of Orthopedic Pathology of the Armed Forces Institute of Pathology, who spoke on "A General Theory of Cancer". Dr. Johnson's style was rapid and his presentation was most vigorous. He presented from a biologist's point of view an attempt to correlate all the known factors involved in neoplasia into an integrated, understandable methodology. He began with Virchow's cellular pathology which is observing its one hundredth anniversary this year. He declared that malignancy must be considered in the light of the three levels on which it operates: the cellular, the field, and the constitutional. He declared that the cell is a biologic energy-conversion unit, comparable to the quantum in physics. He felt that cancer must be considered a variant of normal living processes. He stated that we would all develop carcinoma if we live long enough.

He spoke briefly on the three general types of theory of etiology: "celestial", involves metabolic rests and genes; the "mundane", which considers tars and steroids, fumes and rays, and gremlins; and the "infernal", which tended to ascribe malignancy to evil living, viruses, and DNA.

With an interesting array of sketches, diagrams, and charts he tried to show how there was some truth to each of these ideas; that repair processes when disturbed changed into hyperplasia, and hyperplasia in turn, when it got out of hand, gave rise to neoplasia. He documented most of his observations by references to research pertinent to his theory, and claimed a parallel was to be found in thermodynamics where "open, steady state" systems are recognized to be a function of balance rather than equilibrium.

DORCHESTER COUNTY MEDICAL SOCIETY

ALFRED R. MARYANOV, M.D.

Journal Representative

Dr. Clarence Tinsman was welcomed back to our Society. He has returned to his former position as Dorchester County Health Officer after an absence of several months.

Dr. Witold Winiarz and Dr. Elizabeth Winiarz, having moved to Annapolis, resigned from our County Society. Since Dr. Elizabeth Winiarz was vice president of the Dorchester County Medical Society, Dr. Eugene Traub was elected to that position at the meeting held on October 15, 1958.

The meeting of September 17 was held at the home of Dr. and Mrs. Frederick A. Miller. During the summer months there were two special meetings held because of special problems in our community. The minutes of these meetings were read and approved. Our delegate to the semi-annual meeting of the State Society at Ocean City gave his report. The Society was in agreement with all issues that were voted on by our delegate.

Two years ago the Dorchester County Medical Society raised the question as to whether or not a patient had free choice of physician in compensation cases. To answer this question the Medical and Chirurgical Faculty appointed a committee to meet with our representatives and discuss our letter about changes in the compensation law. Dr. Eugene Traub, who had been appointed our representative, gave the following report:

Present: Judge Lester H. Crowther, Workmen's Compensation Commission, Dr. C. Reid Edwards, Dr. Howard B. McElwain, Dr. Eugene F. Traub and Dr. Nathan E. Needle, Chairman.

Dr. Traub reported that the following motion was passed:

(1) "That it was the consensus of the committee that the patient was to have free choice of physician. However, this was not to be advertised; and Judge Crowther pointed out that it would not be binding to anyone, and

(2) "The committee agreed to get a final ruling from the Attorney General inasmuch as the last ruling was obtained in 1929."

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.
Journal Representative

SOCIETY NEWS

The regular monthly meeting of the Society was held September 16, at the Peter Pan Inn, Urbana. The usual tender steak and succulents were served with gusto and eaten with relish. The guest speaker was Dr. Sol Katz of Washington, who, as expected, gave his usual clear and encyclopedic talk on "Pulmonary Histoplasmosis".

Dr. Hamilton Slusher, after an illness of many months, has announced his retirement. Dr. Slusher had been in active general practice here for nearly forty years. We hope he is now enjoying a leisurely life at his farm in Virginia.

HARFORD COUNTY MEDICAL SOCIETY

FREDERICK J. HATEM, M.D.
Journal Representative

The Harford County Medical Society met on September 24, 1958 at the Bayou Restaurant in Havre de Grace.

Col. Bonsignore, Commanding Officer of the Station Hospital, Aberdeen Proving Ground and Mr. Rittler, Chief of the Medicare section of the Maryland Medical Service, Inc. were present and gave us a resume of the recent changes in Medicare and how they affect physicians practicing in Harford County.

Doctors William M. Leen and Frank Hauber were accepted as new members of the County Medical Society. Dr. Leen is residing in Havre de Grace and is associated with Dr. Charles Marek in the practice of obstetrics and gynecology. Dr. Hauber, also residing in Havre de Grace, is associated with Doctors Ross Pierpont and William Brendle in the practice of general surgery.

The speaker of the evening was Dr. Leo Bartemeir, Medical Director of the Seton Institute. Dr. Bartemeir gave a most interesting talk on Psychiatry in General Practice. Dr. Bartemeir stressed the importance of the patient-physician relationship which is so important in early psychiatric care and which is unequaled outside of general practice.

Work at the Harford Memorial Hospital has been completed. The new pediatric section and the addition to the maternity section are in use and are most welcome additions. Unfortunately, the additional medical-surgical beds provided have not yet been available because of the nursing shortage. It is hoped that a recent pay raise provided by our Board of Directors will enable us to increase our nursing staff and fully utilize our facilities.

TALBOT COUNTY MEDICAL SOCIETY

JOHN N. ROBINSON, M.D.
Journal Representative

A special meeting was held on September 7, 1958. Dr. Robert W. Trever was accepted as a transfer from the Baltimore City Medical Society. Dr. Edwin R. Ruzicka was elected to membership. Progress has been made in setting up our new emergency telephone service.

Deaths: September, 1958—Dr. Roscoe L. Perkins, Royal Oak, Maryland.

Obituaries

Joseph Friedman, M.D.
1906–1958

Dr. Joseph Friedman died October 4 at the age of 52 after many months of illness. He practiced general medicine in Baltimore. He had been on the Commission for the Aged and an examiner for the State Industrial Accident Commission. He was a member of the Baltimore City Medical Society and Phi Lambda Kappa medical fraternity.

Dr. Friedman attended New York University and the University of Maryland Medical School. He interned at Sinai Hospital in Baltimore and then practiced in Westernport in Allegany County. From 1941 to 1947 he served in the Army Medical Corps, following which he established a practice in Baltimore.

Dr. Friedman is survived by his wife and two children, one brother and two sisters.

Eduard Novak, M.D.
1890–1958

Dr. Eduard Novak, one of a well-known family of Baltimore doctors, died October 6. He was 68. A graduate of Johns Hopkins University School of Medicine, he practiced general medicine in the Medical Arts Building.

One of seven brothers, Dr. Novak was the sixth to pass away within the past three years. Three of his brothers, Emil, August and Frank, were also doctors. Surviving him are one brother, Charles J. Novak, a Baltimore attorney, and a sister, Miss Marie Novak. Dr. Novak was a widower and had no children.

In his youth Dr. Novak was an outstanding athlete. In 1912 he and his brother August were sent to Prague to represent the United States in gymnastic games. They were directors of gymnastics in the Public Athletic League and won numerous trophies in local competition.

James E. H. Spence, M.D.

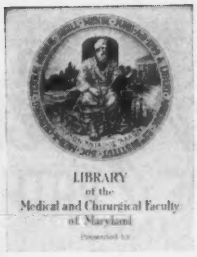
Dr. James E. H. Spence, resident surgeon for the Western Maryland Railway in Hagerstown, died suddenly on September 27. He had held the post of resident surgeon for the past 15 years.

Born and raised in Orangeville, Ontario, Canada, Dr. Spence received his degree from the University of Toronto, Toronto, Canada. He is survived by his wife Mrs. Clara Spence of Hagerstown and brothers John and David Spence, both of Orangeville, Ontario, Canada.

Funeral services and interment took place in Toronto, Canada.

Nothing in life is more wonderful than faith—the one great moving force which we can neither weigh in the balance nor test in the crucible.

SIR WILLIAM OSLER



Library

Louise D. C. King *Librarian*

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *Ibn Tibbon*

Some Recent Acquisitions

Allan, W. S.	Rehabilitation: a community challenge.	1958
Allen, F. H., Jr. & Diamond, L. K.	Erythroblastosis fetalis.	1958
Allen, J. G., ed.	Extracorporeal circulation.	1958
Bayley, R. H.	Biophysical principles of electrocardiography.	1958
Blacklock, D. B. & Southwell, Thomas	Guide to human parasitology for medical practitioners.	1958
Burket, L. W.	Oral medicine.	1957
Burrow, Trigant	Search for man's sanity.	1958
Burwell, C. S.	Heart disease and pregnancy.	1958
Buxton, C. L. & others	Human infertility.	1958
Calkins, L. A.	Abnormal labor.	1958
Cantarrow, Abraham	Biochemistry.	1957
Christopher, Frederick	One surgeon's practice.	1957
Churchill, E. D.	In the vineyard of surgery. J. Collins Warren, 1842	1958
Cleave, T. L.	Fat consumption and coronary disease.	1958
Cohen of Birkenhead, 1st Baron	Sherrington, physiologist and philosopher and poet.	1958
Cushing, J. E.	Principles of immunology.	1957
Diamond, H. D.	Medical management of cancer.	1958
Dill, L. V.	Modern perinatal care.	1957
Directory for exceptional children, educational and training facilities.		1958
Dripps, H. D., ed.	Physiology of induced hypothermia.	1957
Dufault, Paul	Diagnosis & treatment of pulmonary tuberculosis.	1957
Ferguson, A. B., Jr.	Orthopedic surgery in infancy and childhood.	1957
Ficarra, B. J.	Diseases of the thyroid and parathyroid glands.	1958
Freeman, M. B.	The story of Albert Einstein.	1958
Gardiner-Hill, H., ed.	Modern trends in endocrinology.	1958
Glaister, John	Medical jurisprudence and toxicology.	1957
Glasser, Otto	Dr. W. C. Röntgen.	1958
Graham, Harvey	Surgeons all.	1957
Harris, M. C.	Practical allergy.	1957
Hosler, R. T. M.	A manual on cardiac resuscitation.	1958
Hudson, E. H.	Non-venereal syphilis.	1958
James, D. G.	Diagnosis and treatment of infections.	1957
Jarvis, D. C.	Folk medicine.	1958
Javert, C. T.	Spontaneous and habitual abortion.	1957
Kanner, Leo	Child psychiatry.	1957
King, L. S.	Medical world of the 18th century.	1958
Kjellberg, S. R. & others	Lower urinary tract in childhood.	1958
Kossmann, C. E.	Advances in electrocardiography.	1958
Langston, H. T.	Postoperative chest; radiographic considerations after thoracic surgery.	1958
Leavell, H. R.	Preventive medicine for the doctor in his community.	1958
Lee, D. H. K.	Climate and economic development in the tropics.	1957
Licht, Sidney, ed.	Therapeutic heat.	1958
Long, E. R.	Chemistry and chemotherapy of tuberculosis.	1958
McCollum, E. V.	History of nutrition.	1957
Marshall, E. K.	Diagnostic medical parasitology.	1958
Miale, J. B.	Laboratory medicine—Hematology.	1958
Morley, M. E.	Cleft palate and speech.	1958
Naclerio, E. A., ed.	Bronchopulmonary disease.	1957
Natof, H. E.	Cardiovascular collapse in the operating room.	1958
Nelson, T. G.	Tracheotomy.	1958
Noyes, A. P. and Kolb, L. C.	Modern clinical psychiatry.	1958

(*Continued on page 718*)

Maryland
SOCIETY OF PATHOLOGISTS
INC.

PAUL F. GUERIN, M.D., *President*

ROBERT D. SOLOMON, M.D., *Secretary*
Sinai Hospital, Baltimore 5, Md.

EXFOLIATIVE CYTOPATHOLOGY CONSULTATION

One of the most satisfying professional experiences for the physician is the discovery of an unsuspected, yet curable, disease in an apparently healthy patient. Perhaps no single advancement in medicine has brought this more sharply into focus than exfoliative cytology with its detection of asymptomatic cancers.

The high detection rate that can be attained for small *early* cancers of the stomach (80 per cent), cancer of the lung (90 per cent), *early* cancer of the endometrium (80 per cent) and cervix uteri (97–100%) establishes exfoliative cytology as a dependable and valuable diagnostic adjunctive procedure. The greatest return for time and effort expended is in the detection of cancer of the endometrium and cervix.

Four to five of every one thousand women in the general population are harboring cancer of the cervix. Applied to our State, this rate indicates that three thousand Maryland women have asymptomatic, largely curable, cancer of the cervix.

The former lack of adequate cytologic facilities is fast disappearing. Private consultative facilities are presently available in most of our hospitals and laboratories throughout the State and in our two medical schools. They are continually expanding to keep ahead of demand. The State Department of Health is also capable of handling all medically indigent patients not under private care. It still remains the privileged obligation of private medicine, however, to accept many of these patients within its practice.

While all should have benefit of periodic detection procedures, a dangerous situation is developing and a word of caution is needed. As with every diagnostic procedure, exfoliative cytology is fallible and subject to false negatives. Cytologic consultation should be only a part of a physical examination performed by the patient's personal physician. The physician should thus be cautious of "do-it-yourself kits," whereby his secretary or nurse or even the patient can take a smear without a pelvic examination. Not only are these mass procedures unsatisfactory technically, but such "mail order" medicine focuses upon only one part of the patient-as-a-whole.

It thus seems that the best protection presently available for the patient's health, is: (1) a well prepared specimen obtained by the patient's personal physician, during a thorough physical examination, and (2) examination of this specimen by a competent pathologist able to correlate tissue and cytologic findings and who can consult with the clinician when problem cases arise. This type of consultation avoids misunderstanding over findings or inadequate reports which lead to professional dissatisfaction and harm to the patient.

The Heart Page

Gordon Walker, M.D. – Coeditors – Robert Singleton, M.D.

A SERVICE OF
THE HEART ASSOCIATION OF MARYLAND

ARTERIOSCLEROSIS

ROBERT T. SINGLETON, M.D.

From birth to old age, a twofold process effects the walls of arteries leading to arteriosclerosis or "hardening of the arteries". By the age of sixty there is a thirtyfold increase in the thickness of the intima, and reduplication of the elastic layer completes the basic pathology. Further degenerative changes of the tissue layers leads to diseased states seen predominately in older individuals.

It is known that many factors may modify these processes such as diet, emotional tone, trauma, hypertension, heredity, and environmental factors. Of these modulating variables, diet has received much of the current emphasis. There are many reasons for this. One is the increased incidence of atherosclerosis observed in groups with a high fat intake. Another is the discovery many years ago that atherosclerosis can be produced in the laboratory animal by feeding certain diets. The increased incidence of atherosclerosis associated with obesity as well as in those patients who have abnormal lipid metabolism invites further dietary investigation. From a practical standpoint, diet is one of the more tangible variables mentioned above and lends itself readily to more rigid laboratory control. Also to be noted is the profit derived from dietary fads that undoubtedly stimulates research by many drug concerns.

Of particular interest with respect to diets is the lipid content, both in amount and type. The serum cholesterol level has proved to be a valuable index of dietary intake of lipids as well as signaling abnormalities in fat metabolism. Most diets employed in the clinical research of atherosclerosis are aimed at lowering blood serum cholesterol. Although there have been many conflicting reports regarding the efficacy of these diets, it might be worth while to mention some of the more obvious evidence accumulated.

The total fat intake, the type of fat (i.e. animal, vegetable or marine), the relative saturation of the fat and the intervals between feeding are all important factors to be considered. Obesity usually is the result of excessive caloric intake. Since fat contains over twice as many calories as other food, weight for weight, it seems reasonable that fat intake should be restricted to prevent or treat obesity. In general, the unsaturated vegetable or marine fats tend to lower the serum cholesterol whereas the hydrogenated vegetable or saturated fatty acids tend to elevate the serum cholesterol level. The degree of saturation probably influences the esterification and ultimate metabolism of cholesterol itself. Also to be considered are the carbohydrate and protein intake since they also affect the anabolism and catabolism of cholesterol to a lesser degree.

With regard to current recommendations, Page and his co-workers (1) recently pointed out that the alterations of dietary patterns of a large population may be dangerous in light of our present restricted knowledge of nutrition. Common sense should dictate that, to be ideal, a diet should be balanced and varied and should contain the total calories suited to individual needs. Fats should be restricted to include only 25–30 per cent of the total calories instead of the usual 40–45 per cent. Obviously, already diseased patients and those who have a strong family history of early death from cardiovascular disease require much more rigid and tailored restrictions to fit their individual cases. The general use of supplemental unsaturated fatty acids certainly does not appear warranted from the evidence available to date.

Although diet has been stressed as a factor in atherosclerosis, it should be pointed out that existing evidence does not permit a rigid stand on the relationship between dietary intake and "hardening of the arteries". Continued basic and clinical research presently undertaken holds the key to the future importance of fat and the diet in the production of atherosclerosis and other degenerative forms of arteriosclerosis.

1527 Langford Road
Baltimore 7, Md.

REFERENCE

1. Stare, Corcoran, Pollack, Page and Wilkinson. Circulation **16:** 163. August, 1957.

Blue Cross - Blue Shield

BLUE CROSS-BLUE SHIELD AND THE AGED

DENWOOD N. KELLY*

The fact that Americans today live longer is common knowledge. Demographers tell us that about one in every twelve persons of our population is 65 years of age or over and that this ratio will change within the next fifty years to one in eight. Of those over 65, about two-thirds are between 65 and 75 years old with most of the remaining one-third being between 75 and 80.

By and large, these people in the over-sixty-five category do not have incomes adequate to enable them to completely finance their medical care. A national survey made about three years ago indicated that only one out of every three aged persons had annual incomes of their own equal to or in excess of $1,000. And it is precisely in this age group that there is the greatest need for medical care. Here in Maryland, for example, Blue Cross members over 65 have a hospital admission rate about 40 per cent higher than that for all members, regardless of age. Not only do they receive this hospital care more frequently, but their average stay per admission is 42 per cent longer and their average cost per case some 60 per cent higher than that enjoyed by the total membership. Thus, the dilemma of the aged can be very succinctly stated: "relatively low income versus an increasing need for care."

There is no easy solution to this total problem, but much has been done in recent years to alleviate it in part. Many of the people already in the over-sixty-five age group and a large percentage of those about to enter this group now have health insurance by virtue of their employment or as a result of their own providence. It is the universal practice of Blue Cross and Blue Shield Plans to not only permit, but to encourage, these people to continue membership after their retirement and after they reach the age of 65. In addition a majority of the Blue Plans will permit group enrollment of people who have already reached 65 as long as an acceptable percentage of all employees is enrolled. Blue Cross and Blue Shield have always recognized the problem of the health care of the aged and, for that reason, have encouraged in every way possible the retention of membership by older citizens.

Here in Maryland, Blue Cross-Blue Shield members who are enrolled on a non-group or direct-pay basis retain the same level of coverage they have always enjoyed, regardless of their attained age, and at the same rate paid by all other members of the community enrolled in the same class of membership. If the older person has standard group membership through his place of employment and retires, he may retain the same level of coverage, at the slightly higher rate for the direct-pay membership. In its recent ruling on the Blue Cross request for increased rates, the State Insurance Commission further protected the interest of the older member by shifting some of the premium cost from the direct-pay to the group rate where the membership is largely among younger people. By this device, the younger person carries some of the load for the older citizen against the day when he will likewise qualify for such an advantage. Blue Cross-Blue Shield go one step further to benefit the retired employee. If his employer has a retirement program which will permit the deduction and payment of Blue Cross-Blue Shield rates from the retiree's pension, the lower group rates are willingly made available. The only requirement is that the employer make himself responsible for the collection and payment of the monthly charge. Here the retiree not only receives a lower rate, but also has his premiums paid in the manner which works the least financial hardship on him.

As time goes on and as retirement programs increase in number and scope, more and more of our senior citizens will find that they have good protection against medical expenses during their declining years. However, there are at present a substantial number of people who have reached 65 and who have no protection whatsoever. These people constitute a real problem as most of them are not now able to purchase acceptable coverage even if they can afford it. In all probability, this situation will be improved before too long as Blue Cross and Blue Shield nationally are currently engaged in extensive research leading toward the provision of coverage for the aged who can purchase it.

Leaders of Blue Cross Plans and of the insurance industry have already met for the purpose of developing means for financing the major health needs of the retired aged within the voluntary framework.

* Assistant Director, Maryland Medical Service, Inc.

(*Continued on page 722*)

Health Departments

PROPOSED PLAN FOR THE CONSTRUCTION OF PUBLIC AND NON-PROFIT NURSING HOMES

STATE DEPARTMENT OF HEALTH 1959 LEGISLATIVE PROGRAM

HERBERT G. FRITZ*

Nursing homes, the newest category of medical facilities, because of their impact on the various medical programs, are being given highest priority in the State Department of Health Legislative Program for 1959. The proposal which the Department will present to the Legislature would make available $1,500,000 of State funds to supplement Federal funds already available and local funds to be provided for the construction of public and non-profit nursing homes. The objective is to provide 500 additional nursing home beds during the next five years. It is intended that the combined State and Federal funds cover two-thirds of the cost of building and equipping these nursing homes. The figure of 500 beds is calculated on the current population of the State at a ratio of one and one-half beds per thousand population and takes into account beds in all nursing homes now in operation.

General and chronic disease hospitals are in the incongruous situation of holding on their waiting list patients who need hospital level of care while some patients occupying their beds need only nursing home level of care. Patients occupying the beds after medical discharge do not have homes to which to return or their needs are beyond the capacity of their homes. They are candidates for nursing home beds. Hospitals and other agencies seeking places for patients report that weeks, and frequently months, elapse before an available nursing home bed can be found. Even though there are beds vacant in proprietary nursing homes, these beds are not available to patients in the low-income brackets or welfare clients.

In the case of the general hospitals, a bed costing $25,000 to $30,000 to provide and $25.00 to $33.00 per day to service is occupied by a patient whose needs could be met in a $5,000 nursing home bed at a cost of from $5.00 to $8.00 per day. Patients with financial means sufficient to pay the price asked by the commercial nursing home operator have no problem. Operators of commercial nursing homes state they have from four to five hundred beds vacant at all times, but these beds are available almost exclusively to patients who are able to pay the rates charged. They would accept welfare clients into these vacant beds if the State would raise its grants sufficiently. Raising of welfare grants would help this indigent group but it would not solve the problem of the self-supporting pensioners and low-income groups.

The plan proposed by the State Department of Health is intended to resolve this situation. An organization which would be eligible for State and Federal construction funds would have as its primary objective, fulfilling the community need. It would not look upon this program as a commercial venture with a profit motive. Ability to pay the cost would not be the primary consideration in acceptance of patients.

Applications for construction funds would be given priority according to the degree of local need. Those from areas with the least number of beds in proportion to population would be given first consideration. The type of sponsorship would make it possible to admit patients with low incomes and those with difficult medical problems, such as obesity, incontinence, or advanced cancer. the types of patients the proprietary nursing home operators do not welcome. The program, therefore, is not intended to replace the existing nursing homes but to be complementary to them.

The law which authorized the State Chronic Disease Hospital Program fixes the number of hospitals at three but does not limit the bed capacity. When new construction underway and remodeling of old buildings is completed at Montebello Hospital, the total capacity for the three hospitals will be approximately 1,100 beds.

If the patients in the three state-owned chronic disease hospitals can be limited to those *needing hospital level of care*, the 1,100 beds should be sufficient for the foreseeable future. However, if waiting lists continue after these hospitals are staffed and operating at capacity, public pressures will develop to add to the number of beds either by building additions to the three existing hospitals or by the con-

* Chief, Division of Hospital Services, Maryland State Department of Health.

struction of additional hospitals. If the cause of the waiting lists is occupancy of beds by patients who are medically discharged and whose needs could be met at the nursing home level, then the solution lies in providing more nursing homes.

The state's Plan favors nursing home construction as an alternative to expansion of the chronic disease hospital capacity. Its advantages are financial, social and political. It is obvious that to keep patients in general or chronic disease hospitals when their needs could be met in nursing homes is ineffective use of facilities representing large capital investments and wasteful of costly services.

Underlying and seriously affecting the problems of the aged is the concern or lack of concern of the family. If the only facility available is a bed in a chronic disease hospital at some distance, the spouse or other relative who is concerned, objects to the separation. As a result, care may be refused to the detriment of the patient and the serious handicapping of the household. On the other hand, relatives who are indifferent and who look upon the aged person as a burden, are glad to send him a great distance to get him "out of sight and out of mind".

The chronic disease hospitals must be few in number and located at central points because they must employ costly and scarce staff members with special skills. When distance is weighed against special services, services is the controlling factor. However, when the patients' medical needs are reduced to the point where they can be adequately met by nursing and personal care, the weight is on the side of locating the facility near the patients' home and family.

It is quite apparent that there is a problem and a solution. This leaves for answer the question of the source from which the solution should be provided and the continuing responsibility for administration. Should the state or local groups be responsible?

It is customary for the state to provide only those services which are known to be needed but which are beyond the financial ability of the individuals or the local communities to provide for themselves. Chronic disease hospitals functioning at a rehabilitation hospital level of care cannot be duplicated in every political subdivision. It is therefore quite appropriate that the State provide these services and facilities. Nursing homes, preferably small homelike facilities which render nursing and personal services under medical supervision, can and should be established at the community level.

Communities faced this problem in earlier years only to the extent of providing almshouses which operated at such a low standard of care that the aged and mentally defective went or were taken "over the hill" only as a last hopeless resort. In recent years, through the success of medical science in extending the span of life, the aged segment of the population has increased at a greater rate than any other group. Concurrently it has been found that with proper rehabilitation services many persons who formerly were considered totally and permanently disabled can be rehabilitated to a degree of self help which permits them to return to their community and to normal family life.

The modern small home or apartment-type of dwelling is usually unsuitable to house three generations. The older generation if afflicted only with infirmities of old age is left to find lodging in foster homes, boarding homes or other domiciliary facilities. Those with physical and medical problems requiring nursing and personal services must look for space in nursing homes.

The placing of welfare grants on a cash basis and the broad coverage of social security payments as well as pensions has placed a limited amount of cash in the hands of most older people. With the advent of cash payments, entrepreneurs, seeing a profit potential, rented large old homes, employed nurses and other staff and offered their services as proprietary nursing homes. Many have done quite well financially while rendering a satisfactory level of care. This is particularly true in those homes which accept only patients with sufficient resources to pay their own way.

Pensions and welfare grants usually are not sufficient resource out of which to pay the cost of nursing home care. Operators of proprietary nursing homes say "raise the amount of welfare grants". The State Department of Health and the State Department of Public Welfare, cognizant of the rising labor and food costs and costs in general, are making a joint study of this problem. An adjustment of welfare grants alone will not solve the problem. It is doubtful whether the adjusted rates would be equal to what the nursing home operators consider adequate. It is therefore doubtful whether commercial nursing home operators will accept difficult cases even with an increase in the welfare grants. An adjustment in welfare grants would not affect fixed pensions or the income of children who hold jobs with moderate incomes out of which they try to maintain their

families and also make payments for their parents' care in nursing homes. The problem will be only partially met by the commercial nursing home, even with higher welfare grants, leaving the low-income group, the pensioners and certain of the welfare group without a satisfactory solution.

Operators of commercial nursing homes established as private enterprise with a profit motive have exercised the prerogatives of private industry by establishing their places of business in areas with the greatest potential for profit. This has resulted in nursing home beds being available to a reasonable degree of adequacy in areas such as Montgomery, Baltimore and Washington Counties and Baltimore City, leaving large areas of the State with few, and in some areas no facilities. Since the problem can be solved at the local level, and since the proprietary nursing homes have not met the needs of certain geographic and social areas, either local public bodies or voluntary non-profit groups can provide a solution.

Public bodies would include county or city governments. Non-profit voluntary groups would include organizations similar to those operating the voluntary non-profit hospitals. Voluntary hospitals may be applicants. Both groups would have as their primary concern the needs of the residents of their area. They could serve those needs, knowing that if a deficit resulted, they have the resources of the community to call upon. Commercial operators do not have this resource and therefore quite justifiably refuse admission to a patient if a loss is apparent.

Federal funds are available as grants under the Hill-Burton Program to non-profit and public groups for use in building and equipping nursing homes. The funds are very limited. The program of the State Department of Health calls for the use of state funds to supplement federal grants so that eligible sponsoring groups may be given funds sufficient to cover two-thirds of the cost of construction and equipment. Several groups in areas where there is need for nursing home beds have stated they will raise the remaining one-third of the cost of establishing a nursing home if they can obtain federal and state grants sufficient to cover two-thirds of the cost.

The action of the Legislature by approving this request would:

1. Insure that the state chronic disease hospitals would serve the state effectively by having their beds occupied by patients who need hospital level of care.

2. Recognize that nursing home facilities and nursing home patient care are a local responsibility, thus giving assurance that the capacities of the chronic disease hospitals would not be expanded for this purpose.

Summary

1. The State Department of Health proposes a plan for construction of non-profit and public nursing homes with two-thirds of the cost of construction and equipment to be covered by State and Federal funds.

2. General and chronic disease hospitals have lists of patients waiting for admission while their beds are occupied by patients whose needs could be met in nursing homes.

3. Low-income and welfare groups because of their limited resources cannot gain admission to proprietary nursing homes in spite of vacant beds.

4. Chronic disease hospitals have a sufficient number of beds to meet the needs of rehabilatable patients provided that patients who have reached maximum hospital benefit can be discharged expeditiously.

5. Nursing home facilities and services can and should be provided at the local level.

6. Proprietary nursing homes have adequate numbers of beds for those patients with sufficient resources to pay their own way.

7. Raising welfare grants would not solve problems of self-supporting persons on fixed pension or those whose only resource is the limited income of their children.

8. Non-profit voluntary and public groups can concentrate entirely on the needs of the patients without consideration of the patients' ability to pay because they may, in the case of a deficit, call upon the community resources.

9. Through this program the state would recognize nursing home establishment and operation as a local and not a state responsibility.

BALTIMORE CITY HEALTH DEPARTMENT

Medical Care For The Aged

The Baltimore City Health Department, since the inception of the City Medical Care Program in 1948, has had a direct responsibility for the physician and dispensary clinic services for welfare clients of all ages. The elderly form the largest group after the children, approximately 18 per cent being over 65 years and 43 per cent under 15 years of age. Public funds are also available for outpatient and inpatient hospital services for the medically indigent of all ages in Baltimore City.

Perhaps the closest active part of City Health Department work for the aged has been the membership of the Commissioner of Health and the Assistant Commissioner of Health for Research and Planning on the Baltimore City Commission on Aging and the Problems of the Aged. The work of this Commission culminated several years ago in a report entitled "Widening the Lengthened Path of Life," copies of which are available by writing the Baltimore City Health Department. In the report, recommendations will be found in such areas as economic security, housing, recreation, social services, and medical care. At the present time, the Commission is promoting through private sources the establishment of a center for senior citizens which would serve to house counselors in adult education, employment opportunities, housing and in medical care facilities. In addition, the center would be equipped with a workshop and serve as a cultural and social focus for elderly residents of the metropolitan area.

Published in this number of the Journal is a study of nursing homes conducted jointly by the City Health Department and State Department of Health at the request of the Geriatrics Committee of the Medical and Chirurgical Faculty of Maryland. Such investigation is made possible through the capabilities of the Research and Planning staff of the Baltimore City Health Department.

Huntington Williams, M.D.

Commissioner of Health

Library

(*Continued from page 711*)

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Woman's Auxiliary Medical and Chirurgical Faculty

MRS. DAVID S. CLAYMAN, *Auxiliary Editor*

A HAPPY HOLIDAY SEASON

MRS. DAVID S. CLAYMAN

As we approach the Christmas season and the New Year 1959, let us re-examine our tasks and our goals as well as the means we are employing to attain them.

May these coming days bring to us an awareness of the heavy responsibilities which rest upon us as women, as Americans and as doctors' wives. As we plan our activities for the coming year, may we remember that the only activities which really matter are those which serve to advance our faith in man's ability to create a better world of life, health and peace. May the New Year bring us the joy of knowing that through our labors we are contributing in some measure to the health of our communities and to the welfare of our nation.

A most happy holiday season to all.

YOUR AUXILIARY EDITOR

15TH ANNUAL CONFERENCE

MRS. DELMAS CAPLES, *President-Elect*

State Presidents, Presidents-Elect, National Officers and Chairmen, Drake Hotel, Chicago, Ill., October 6–8, 1958

Theme: Auxiliaries In Action.

The 15th Annual Conference opened with a continental breakfast at 8:30 A.M. on October 6, 1958 with conference members as guests of the Auxiliary. The Vice-Presidents and the Presidents of their states were hostesses.

The meeting was called to order at 9:30 A.M. by Mrs. E. Arthur Underwood, President. After the invocation by Mrs. James P. Simonds, the meeting was turned over to Mrs. Frank Gastineau, the presiding officer.

Dr. Ernest B. Howard, Assist. Executive Vice-President of A.M.A., gave us a talk on "AMA Round-up". He said that we should take a look at the things that are taking place in the AMA.

1. Reorganization of AMA by Dr. Blasingame, Executive Vice-President of AMA.
2. Remodeling of the AMA building; to cost 2½ million dollars.
3. New AMA News. Mr. Reed as editor.
4. To-day's Health.
5. A.M.A. Research Foundation being set up with medical and private outside help from 6 to 9 months hence.
6. Medi-care Program.
7. Program on Aging.
   The next two years the medical profession will be trying to resolve some of the aging problems. Financing remains a problem. Private non-government resources will increase activity to provide better coverage of the over 65 year group.
8. Installment payment plan for Nursing Home expansion.
9. Joint commission of AMA, AHA, and the ANHA.
10. Free choice of physician.
11. Osteopath—Possibilities of Osteopath and medicine moving closer together.
12. Voluntary Health Insurance Plan. (Blue Cross) Economic reasons forcing Blue Cross to require increase in premiums. Trying to keep program on paying plan.
13. Voluntary Health and United Fund. Whether or not a medical society and Auxiliary participate in local drives is up to the local society.

Legislation—MRS. GOODHAND

Mr. Joseph Stetler, Director, Law Division, AMA, stated that there were 21,000 bills introduced in the 85th Congress, 704 were on medicine. Twenty were enacted. He said more bills were not passed because the country was involved in international affairs, the recession, and an election year. A large number of the bills were to liberize the already existing Social Security law. The Forand Bill—HR4967—will be of extreme importance in the 86th Congress. This bill, if passed, will have a tremendous effect upon the quality of medicine. It is attractive to the public and Congress. We must take steps in private enterprise to plan to solve this problem. The Joint Council will begin meeting during January 1959 to discuss problems of aged.

The Jenkins-Keough bill was released by the House ways and means committee too late to have hearings in the 85th Congress. If the house passes it early it will go through the 86th Congress.

The medical profession cannot stand alone, we must get help from other organizations. We must impress this upon the doctors, as well as allied groups and the public. Dr. Allman once said "Any government that is big enough to give you everything you want is also big enough to take everything away from you". The best way to fight Social Security is to stay out of it altogether. In January 1960 the White House Conference on Aging will be held. State medical societies are urged to participate with the Joint Commission in their states.

The Do's for Including Members-at-large

1. Dues paying. Make her as active as possible. Use as hostess, to arrange music for affairs, flowers, and as special chairman. Send her material that is available. We need to use old members with new members on committees "To think anew is to act anew".

2. "Do-gooder". Place on projects committee in community service.

3. "Executives". Place for all of them. Put on organization or by-laws committee. Have her talk-up the auxiliary. Fund-raising, AMEF, card parties.

4. Artistic. Poster committee. Arrange a hobby show for auxiliary.

5. Listeners. Something may prevent active participation. Keep talking to them.

6. Talkers. Put on speakers bureau for all auxiliary projects. Use her to reeducate the lost member. Enlarge every committee.

New Blood. Secure new blood. Get list of new members from Exec. Sec. of medical society. Give them a job.

Tired Blood. Older members. Seek them out and try to give a boost. Have them pick up new member. Help to give tea honoring new members. Have her get a list of interests and talents of new members.

Baby-sitter Trouble. Might prevent member from attending. Train "Gems".

SAMA Members. Have been sent cards asking that they notify county auxiliary when member goes into county.

Activity is the key to membership. Unity is the key to the program.

Bulletin Committee—MRS. E. M. EGAN

Each county and state should keep a Bulletin File to refer to in times of need. There is a new Bulletin pamphlet available from the auxiliary office called "Know Your Bulletin". Try to give each new member a subscription so that she may know something about the auxiliary.

NOMINATING COMMITTEE SELECTED

MRS. WHITMER B. FIROR

At the semi-annual meeting held in Ocean City September 12, the following members were appointed to serve on the nominating committee for 1958–1959:

Mrs. Ernest F. Poole—Washington County
Mrs. Samuel Allen—Montgomery County
Mrs. Waldo B. Moyers—Prince Georges County
Mrs. Walter M. Hammett—Baltimore County
Mrs. Whitmer B. Firor, Chairman—Baltimore City

The committee would welcome suggestions in writing for nominations for the following officers:

President Elect
First Vice President
Second Vice President
Third Vice President
Fourth Vice President
Treasurer
Recording Secretary
Corresponding Secretary

Book Reviews*

Callander's **Surgical Anatomy,** Barry J. Anson, M.A., Ph.D. (Med. Sc.), Chairman Department of Anatomy, and Robert Laughlin Rea Professor, Northwestern University Medical School, and member of the staff, Passavant Memorial Hospital and Walter G. Maddock, M.S., M.D., F.A.C.S., Edward S. Elcock Professor of Surgery, Northwestern University Medical School, and chairman of the Department of Surgery, Chicago Wesley Memorial Hospital. W. B. Saunders Company, Philadelphia and London. 1157 pages, 1047 illustrations, $21.00.

The authors give credit for help in preparation of the fourth edition of this book to, among many others, Amos R. Koontz, M.D. The rationale, rather than the detailed steps of surgery, are stressed. Techniques change, but anomalies of the human body merely vary in the population, between predictable limits determinable by laboratory and clinical study. This is an excellent reference volume and one worth having.

Handbook of Respiration, Analysis and Compilation by Philip L. Altman, John F. Gibson, Jr., M.D. and Charles C. Wang. Edited by Dorothy S. Dittmer and Rudolph M. Grebe. Prepared under the direction of the Committee on the Handbook of Biological Data, Division of Biology and Agriculture, The National Academy of Sciences, The National Research Council. W. B. Saunders Company, Philadelphia and London. 403 pages. $7.50.

With the interest being expressed over the various forms of respiration and with new techniques and procedures being established, this volume provides concise information compactly organized. This is a book that should be on the book shelf of everyone concerned with this subject.

Physical Examination of the Surgical Patient, J. Englebert Dunphy, M.D., F.A.C.S., Professor of Surgery, Harvard Medical School; Director of 5th Surgical Service and Sears Surgical Laboratory, Boston City Hospital; Consultant in Surgery, Children's Medical Center, and Thomas W. Botsford, M.D., F.A.C.S., Clinical Associate in Surgery, Harvard Medical School; Associate in Surgery, Peter Bent Brigham Hospital; Associate in Surgery, Children's Medical Center. W. B. Saunders Company, Philadelphia and London. 375 pages, 203 figures; second edition. Illustrated. $8.00.

In this book, Dr. Dunphy and Dr. Botsford have gathered together a guide to those important features of physical diagnosis which are not included in the conventional works on examination of the chest. These are the methods of observation, of palpation, of examination of external structures and internal viscera and of deduction.

This is a book of procedure, a book of technique. It has been written as a simple informal statement of how to examine a patient and derive the most information by the simplest means.

Complete Denture Prosthesis, Daniel H. Gehl, D.D.S., Professor of Denture Prosthesis, Marquette University School of Dentistry, and O. M. Dresen, D.D.S., Dean, Marquette University School of Dentistry. W. B. Saunders Company, Philadelphia and London. 542 pages. Illustrated. $11.00.

Certain subject matter from previous printings of this publication have been deleted, while other sections have been elaborated upon by the addition of new text and figures. It is a worth-while book for the dental student and provides much useful information.

Drugs: Their Nature, Action and Use, Harry Beckman, M.D., Director, Departments of Pharmacology, Marquette University Schools of Medicine and Dentistry; Consulting Physician, Milwaukee County General Hospital and Columbus Hospital. W. B. Saunders Company, Philadelphia and London. 728 pages. Illustrated. $15.00.

This textbook is meant primarily for the undergraduate medical student who can devote but a fleeting moment in his career to prepare for the pharmacologic aspects of the practice that lies ahead. It is an excellently documented book, one that every medical student should attempt to obtain and keep for future use.

The Psychology of Medical Practice, Marc H. Hollender, M.D., Professor and Chairman, Department of Psychiatry, State University of New York, Upstate Medical Center, and Director, Syracuse Psychiatric Hospital. W. B. Saunders Company, Philadelphia and London. 276 pages. $6.50.

This book is outstanding in its field. It deals with problems that face every physician and discusses how he should care for patients having a relationship to him out of the ordinary, basic run-of-the-mill visit and treatment.

Pathophysiology in Surgery, James D. Hardy, M.S., M.D., F.A.C.S.; Professor and Chairman, Department of Surgery and Director of Surgical Research, University of Mississippi Medical Center; Surgeon-in-Chief, Hospital of the University of Mississippi. Williams and Wilkins Company, Baltimore.

This volume fuses medical and surgical physiology. It emphasizes the "fundamental unity of the human organism which is achieved through three major coordinators: the nervous system, the circulatory system and the endocrine system." Numerous case studies have been used to further illustrate this union between physiology and daily practice.

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

COMING MEETINGS

BALTIMORE EAR, NOSE AND THROAT SOCIETY

Tuesday, January 13, 1959 Cocktails—6:15 p.m. University Club
Dinner—7:00 p.m.
Meeting—8:00 p.m.

* * * * *

PEDIATRIC SECTION, B.C.M.S.

Tuesday, January 13, 1959 8:30 p.m. 1211 Cathedral Street

* * * * *

TV PROGRAMS, B.C.M.S.

Saturday, 5:00 to 5:30 P.M. WMAR-TV

December 19 "Christmas Safety"
December 26 "World Health Organization at Work"
January 3 "Are X-Rays Safe?" Dr. Robert J. Dickson
January 17 "Recent Advances in Surgery" Dr. Otto C. Brantigan
January 31 "Hypertension" Dr. Caroline B. Thomas and Dr. Katherine Borkovich

Blue Cross-Blue Shield

(*Continued from page 714*)

In addition, the Joint Council to Improve the Health Care of the Aged is also working along similar lines. The four founding organizations of the Council were the American Hospital Association, the American Medical Association, the American Dental Association and the American Nursing Home Association. The Council has a positive program to obtain the facts about the health problems of the aged and then to promote ways and means of alleviating the specific problems either through the expansion of existing facilities or the development of new ones.

Blue Cross and Blue Shield will intensify their efforts to extend their services to that segment of the aging population which can logically be protected under a voluntary prepayment system. In addition, through their close national ties with the American Hospital Association and American Medical Association, they will continue to participate in the various studies and researches now underway so as to assist in every way possible in solving this critical problem.

Official Publication of the
MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND

GERIATRICS ISSUE

Maryland
STATE MEDICAL JOURNAL

7 NO. 12
MBER, 1958

ANNUAL MEETING—WEDNESDAY, THURSDAY, FRIDAY, APRIL 15, 16, 17, 1959

Table of Contents on page V

AGAINST THE UBIQUITOUS HOSPITAL STAPHYLOCOCCUS

CHLOROMYCETIN®

Staphylococci are notorious for the variety of infections they cause and for their ability to develop resistance to certain antibiotics.[1-3] According to recent *in vitro* studies, however, these stubborn pathogens remain sensitive to CHLOROMYCETIN.[3-8]

Highly effective against most strains of staphylococci, CHLOROMYCETIN has been reported of value in treatment for such serious infections as staphylococcal pericarditis,[9] antibiotic-resistant postoperative wound infections,[10] antibiotic-resistant breast abscesses,[3,11] pneumonia due to antibiotic-resistant staphylococci,[12] postoperative staphylococcal enteritis,[13] and septicemia.[14,15]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in several forms, including Kapseals® of 250 mg., bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

REFERENCES: (1) Wise, R. I.: *J.A.M.A.* 166:1178, 1958. (2) Brown, J. W.: *J.A.M.A.* 166:1185, 1958. (3) Caswell, H. T., *et al.*: *Surg., Gynec. & Obst.* 106:1, 1958. (4) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (5) Waisbren, B. A.: *Wisconsin M. J.* 57:89, 1958. (6) Royer, A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783. (7) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (8) Blair, J. E., & Carr, M.: *J.A.M.A.* 166:1192, 1958. (9) Horan, J. M.: *Pediatrics* 19:36, 1957. (10) Rawls, G. H.: *Am. Surgeon* 23:1030, 1957. (11) Sarason, E. L., & Bauman, S.: *Surg., Gynec. & Obst.* 105:224, 1957. (12) James, U.: *Brit. J. Clin. Pract.* 11:801, 1957. (13) Turnbull, R. B., Jr.: *J.A.M.A.* 164:756, 1957. (14) Ross, S.; Puig, J. R., & Zaremba, E. A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 803. (15) Leachman, R., & Yow, E. M., in Conn, H. F.: Current Therapy 1958, W. B. Saunders Company, Philadelphia, 1958, p. 51.

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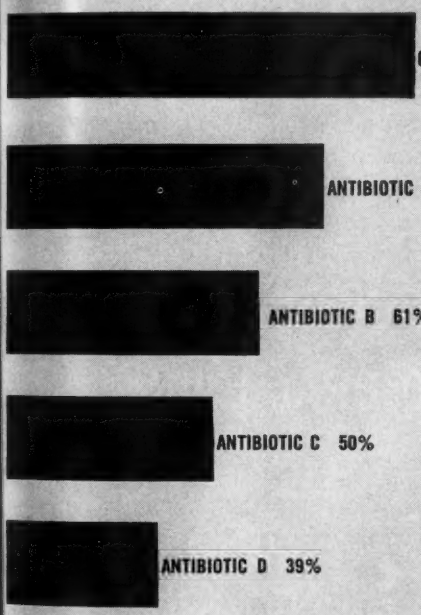
IN VITRO SENSITIVITY OF PATHOGENIC STAPHYLOCOCCI TO CHLOROMYCETIN AND TO FOUR OTHER MAJOR ANTIBIOTICS*



*Adapted from Godfrey & Smith.[4] Staphylococci studied were strains isolated from 28 patients in a general hospital.

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1211 Cathedral Street, Baltimore 1, Maryland
Entered as second-class matter at the Post Office at Baltimore, Md. Acceptance at the special rate authorized
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MARYLAND
STATE MEDICAL JOURNAL
Medical and Chirurgical Faculty of the State of Maryland

1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND

Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

VOLUME 7 | *December, 1958* | NUMBER 12

CONTENTS

EXECUTIVE SECRETARY'S NEWSLETTER

December, 1958

PERSONALITIES

Dr. Norman E. Sartorius, Jr., has been elected President of the Worcester County Medical Society. Other officers include Dr. Robert A. Grubb, Vice-President; Dr. Clifford E. Schott, Secretary-Treasurer; Dr. Robert C. LaMar, Delegate; and Dr. N. R. Thomas, Alternate Delegate and Censor. Dr. Nicholson J. Eastman and Dr. Winthrop M. Phelps were guest speakers at the American Academy for Cerebral Palsy in Dallas. Dr. Timothy D. Baker spoke on his recent experiences in India. Dr. Kurt L. Lederer was honored in Queen Anne's County recently when members of the local Lions Club presented him with a plaque commemorating his service "as the community's only doctor, a conscientious man." Dr. Frank B. Thomas, III, has opened his office for the practice of medicine in Hancock. Dr. E. Cowles Andrus was honored with the "coveted gold heart" award at the meeting of the American Heart Association in San Francisco. Dr. Louis Krause was guest speaker on Educational and Retirement Problems of Older People at an Adult Education series in Baltimore. Dr. Ernest F. Poole represented the Faculty at the dedication of the new Cancer Research Laboratory in Hagerstown. Dr. John A. Myers spoke at Annapolis and in New York on Energy Released Through Food. Cmdr. John I. F. Knud-Hansen, Annapolis, has been named a Fellow of the ACS. Dr. Harold Rosen spoke on Hypnosis, Mental Hygiene and Magic, recently. Dr. F. J. Hatem has agreed to head up the Harford County Christmas Seal Drive. Dr. Edward A. Kitlowski was a speaker on the Program at the American Society of Plastic and Reconstructive Sur ery in Chicago. Named to membership in the American Medical Writers Association are Drs. Dorothy Fogel and John D. Teasdale. Participants in the third annual Nurses Cancer Conference were: Drs. Warfield M. Firor, George G. Finney, Samuel Morrison, John M. Dennis, John K. Frost, Allan R. McClary, and Donald W. Benson. Dr. Amos R. Koontz attended the AMA's Committee on Federal Medical Services meeting in Minneapolis recently.

COMMITTEE ACTIVITIES

The Scientific Work & Arrangements Committee nearing completion of its plans for the 1959 Annual Meeting and making preliminary plans for the 1959 Semiannual and 1960 Annual Meetings; The Committee to Meet With Labor Leaders and Unions in Maryland entering into discussions with representatives of the AFL-CIO. The Planning Committee discussing many subjects for recommendation to the Council and the Veterans' Medical Care Committee meeting to discuss a proposal from the V.A. for a statewide fee schedule

NEWS NOTES

The Department of Physical Therapy of the U. of Md. School of Medicine has received full approval from the Council on

IEWS NOTES (continued)

Medical Education and Hospitals of the American Medical Association. The Rural Health Committee is considering a meeting early in the new year to discuss the entire question of Rural Health. The Bureau of Public Assistance reports that of $302 million paid out for medical care during the 1957 calendar year, only $21.7 million was paid to physicians, with the balance going to hospitals, nursing and convalescent homes and drugs and supplies. Invariably, when a total figure is used, such as $302 million, the public obtains the impression this all went for physicians' services.

LOCAL OPTION

The annual report of the AMA Judicial Council notes that, "From time immemorial the Council has pointed out that the component society is an autonomous group and that as such, one of its principal duties is to apply ethical principles. Apparently this obligation is not recognized clearly by the majority of component societies or is, at best, not accepted as a principal obligation...The Council has noted a failure on the part of physicians to turn to their county medical societies for information concerning the application of ethical principles and the failure of county societies to be more aggressive in developing a sound program of ethics. During recent months the Council's correspondence contained numerous letters from hospital administrators which commence with a statement similar to this: 'One of the doctors on the staff of our hospital is in doubt concerning an ethical problem. He asked me what ethical rule governed. Will you please advise me so I can tell the doctor what his conduct should be.'....The Council urges county and state societies to adopt critical attitudes toward their programs to 'uphold the honor and dignity' of the profession of medicine."

The Faculty Office has available a listing of Judicial Opinions and Reports which can be consulted to find the rulings on most ethical matters that arise from day to day.

)OLLAR WORTH ONLY TEN CENTS

The Tax Foundation, Inc., lists the amount of time it takes an average working man (a typical $4,500 year man) to pay for various items or necessities of living. The breakdown shows how little time he must work to pay for medical care, but how much longer he must work to pay his taxes:

Taxes	2 hours 29 minutes
Food	1 hour 39 minutes
Housing	1 hour 25 minutes
Clothing	37 minutes
Transportation	42 minutes
Medical	24 minutes
Recreation	20 minutes
Other	24 minutes

Total - 8 hours

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from moderate to severe pain complicated by tension, anxiety and restlessness.

CODEMPIRAL'® NO. 3*

Codeine Phosphate	gr. ½
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

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rom pain of muscle and joint origin, simple headache, neuralgia,
nd the symptoms of the common cold.

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Phenobarbital	gr. ¼
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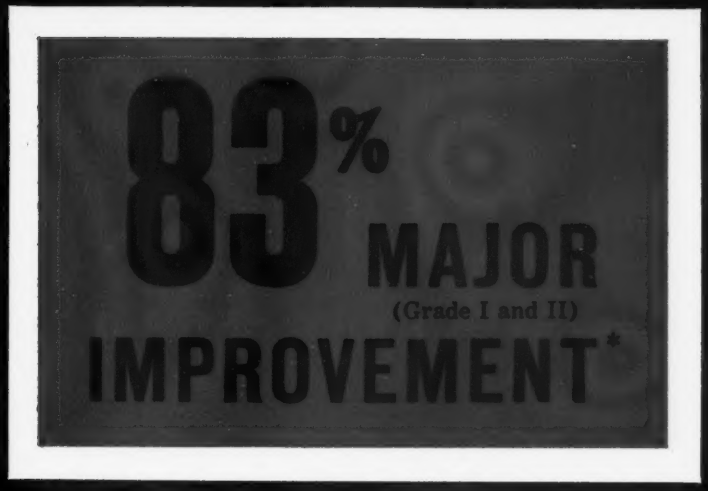

in Rheumatoid Arthritis

*Using combined drug therapy with PLAQUENIL® or Aralen® as maintenance therap With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therapy are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

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ralen (brand of chloroquine) and Plaquenil
rand of hydroxychloroquine), trademarks reg. U.S. Pat. Off.

New York 18, N. Y.

THE RATIONALE FOR THE USE OF VITAMINS IN FORESTALLING INFECTIONS

Many clinicians believe that good nutrition plays a significant role in preventing bacterial infections, and that immunity depends on adequate vitamin levels. Tisdall[1] states that "a low intake of a number of vitamins, a low intake of minerals, and a change in the quality of protein can all lower resistance to infection."

Other studies show the important role of the B vitamins in antibody formation. Thus, *Nutrition Reviews*[2] reports: "Present evidence indicates that certain B vitamins, notably pyridoxine, pantothenic acid and folacin, play a significant role in antibody synthesis." According to Pollack and Halpern,[3] "Under-nutrition leads to increased susceptibility to infection and decreased resistance to established disease." And "vitamin deficiency states also may adversely influence circulating antibodies."

Halpern[4] reports that "good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody production . . . nutrition participates in the prophylaxis against most acute infections . . ."

And while MacBryde[5] feels that evidence is lacking to support the view that a higher than normal intake of vitamins will improve resistance to infection, he also states: "Restoration of nutrition to normal exerts a favorable influence on practically all disease conditions . . . Often the outcome will depend more upon the correction of the malnutrition than upon any therapy directed toward the malady."

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SQUIBB VITAMINS FOR THERAPY

now expanded to include additional essential vitamins—

and at no extra cost to your patients

Each Theragran Capsule supplies:

Vitamin A	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Ascorbic Acid	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B_{12} Activity Concentrate	5 mcg.

Dosage: 1 or more capsules daily as indicated.

Supply: Family Packs of 180. Bottles of 30, 60, 100 and 1,000.

Also Available: THERAGRAN Liquid, bottles of 4 ounces; THERAGRAN Junior bottles of 30 and 100 capsules; and THERAGRAN-M (Squibb Vitamin-Minerals for Therapy), bottles of 30, 60, 100 and 1,000 capsule-shaped tablets.

References: 1. Tisdall, F. F.: Clinical Nutrition, ed. by Joliffe, N.; Tisdall, F. F., and Cannon, P. R.: Paul B. Hoeber, Inc., New York, 1950, p. 748. 2. Nutrition Reviews, *15*:47, (Feb.) 1957. 3. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 18. 4. Halpern, S. L.: Ann. N. Y. Acad. Science *63*:147, (Oct. 28) 1955. 5. MacBryde, C. N.: Signs and Symptoms, J. B. Lippincott Co., Phila., 3rd Ed. 1957, p. 818.

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you were to examine these patients

could you detect the uveitis patient on Medrol*?

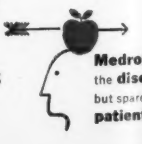
Probably not. Not without a history.

First, because he's more than likely symptom-free.

Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?



Medrol hits the **disease,** but spares the **patient**

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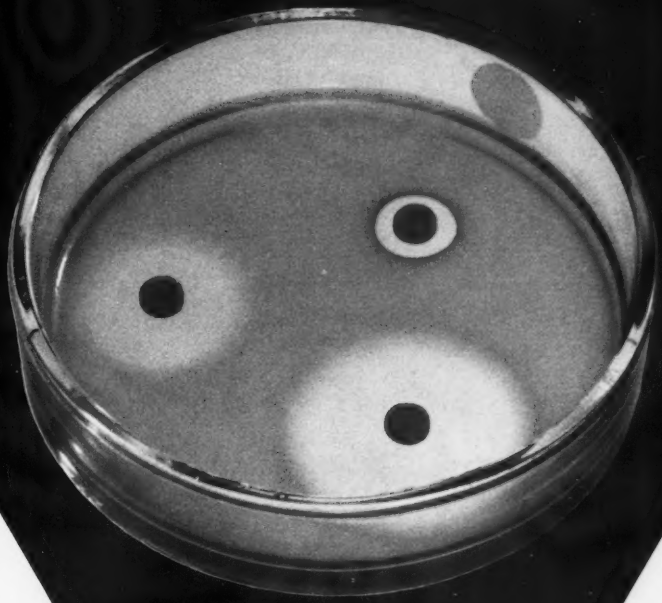

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abbott's antibiotic triad

Erythrocin®

stearate

(Erythromycin Stearate, Abbott)

indications:

In infections caused by staphylococci, streptococci (including enterococci) and pneumococci. Also, against organisms that have become resistant to other antibiotics. ERYTHROCIN should be used where patients are allergic to penicillin or other antibacterials.

dosage:

Usual adult dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours. Child's dose may be reduced in proportion to body weight.

supplied:

In bottles of 25 and 100 Filmtabs (representing 100 and 250 mg. of ERYTHROCIN activity). Also, in cinnamon-flavored oral suspension; 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

® Filmtab — Film-sealed tablets, Abbott; pat. applied for.

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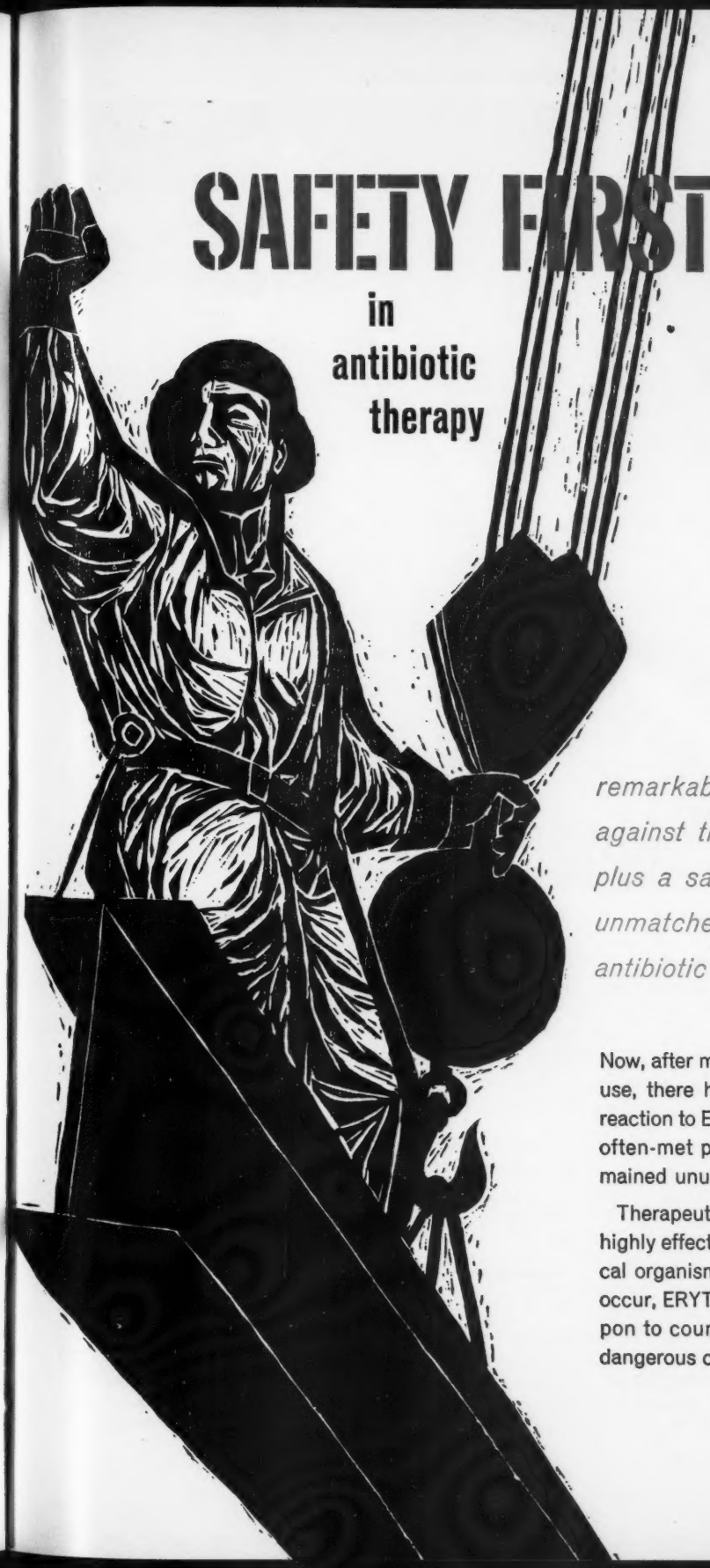

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remarkable effectiveness against the cocci– plus a safety record unmatched in systemic antibiotic therapy

Now, after more than six years of extensive use, there has not been a single serious reaction to ERYTHROCIN. Additionally, the often-met problem of resistance has remained unusually low with ERYTHROCIN.

Therapeutically, you'll find ERYTHROCIN highly effective against the majority of coccal organisms. Where severe viral attacks occur, ERYTHROCIN may well be the weapon to counteract those dangerous complications.

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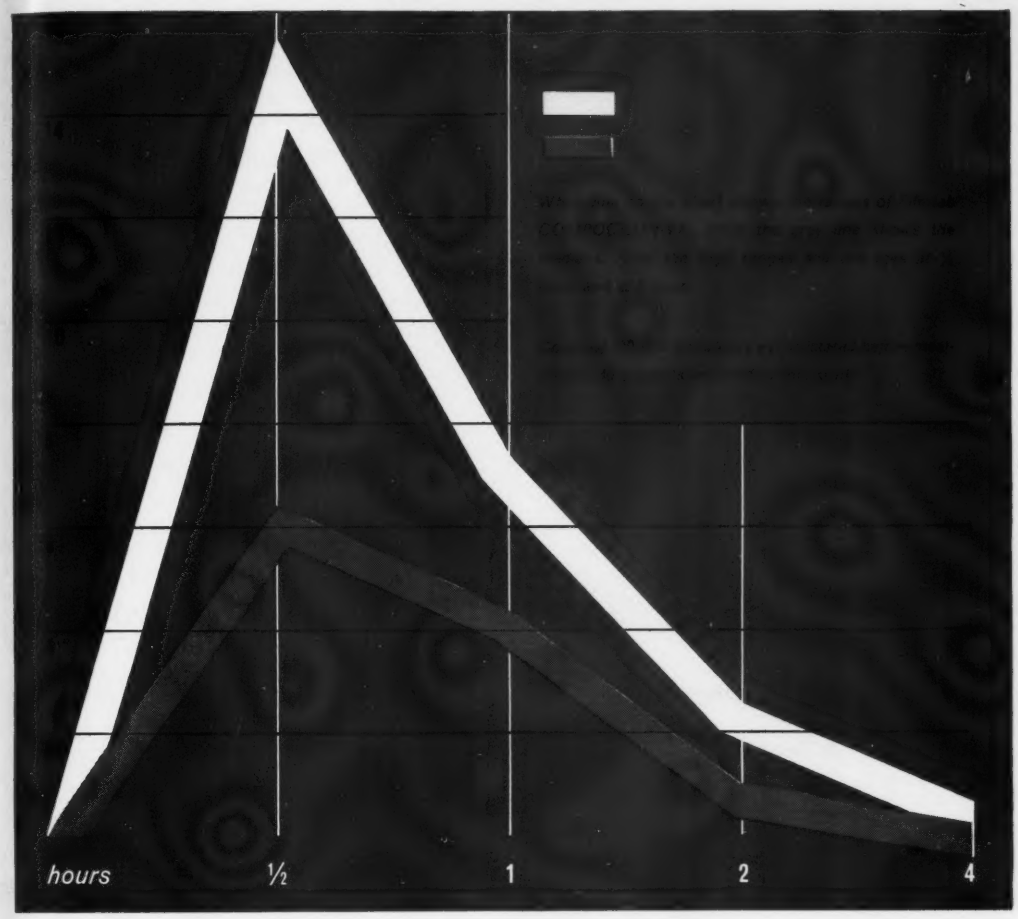


NOW, IN BOTH FILMTAB AND ORAL SOLUTION, patients get high penicillin V blood levels with COMPOCILLIN-VK. Note the chart. Concentrations are three times higher than an equivalent dose of potassium penicillin G.

COMPOCILLIN-VK is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

Indications:

Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and rheumatic heart disease.

Dosage:

Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

Supplied:

In Filmtabs, representing 125 mg. (200,000 units) of potassium penicillin V, bottles of 50 and 100. In 250 mg. (400,000 units), bottles of 25 and 100.

For Oral Solution, COMPOCILLIN-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

COMPOCILLIN-V® Oral Suspension (Ready-Mixed), Hydrabamine Penicillin V, Abbott, comes in 40-cc. and 80-cc. bottles. Each tasty, banana-flavored 5-cc. teaspoonful represents 180 mg. (300,000 units) of penicillin V. At all pharmacies. Abbott

Now, after just 12 months, SPONTIN has become an outstanding drug of choice against resistant staphylococci, and in other serious coccal infections.

Six papers presented at the Antibiotics Symposium[1] reported the effectiveness of SPONTIN against resistant staphylococcal infections. Clinical reponses involved enterococcal endocarditis, staphylococcal pneumonias and staphylococcal bacteremias. Many of these patients were going downhill steadily—in spite of treatment by other antibiotics.

Toxicity? Careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals. A recent report[3] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a safe and potent agent to employ in the treatment of staphylococcal infections."

If you do not have the revised literature on this lifesaving antibiotic, please contact your Abbott Representative soon; or write direct to Abbott Laboratories, North Chicago, Illinois.

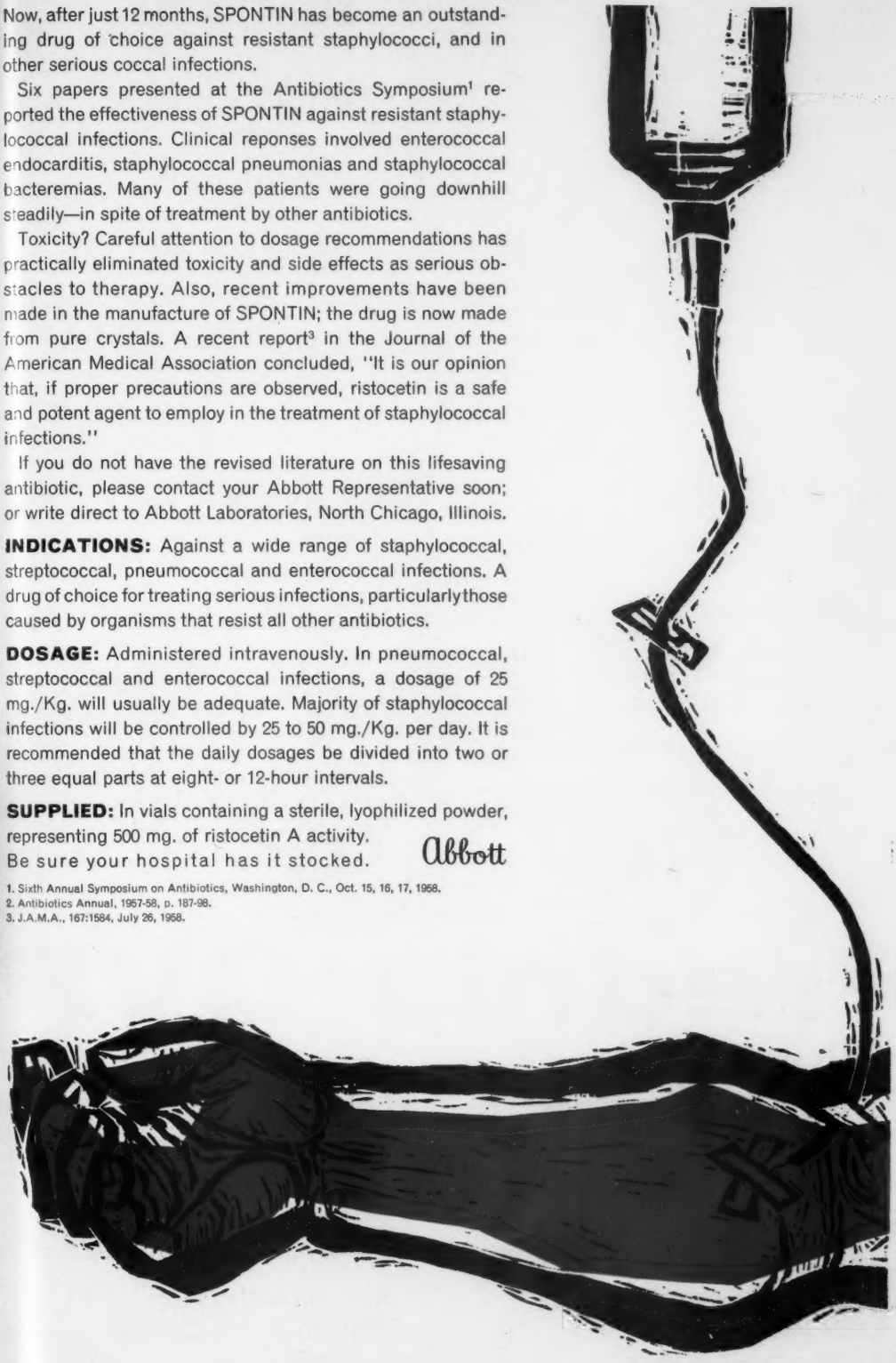
INDICATIONS: Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections, particularly those caused by organisms that resist all other antibiotics.

DOSAGE: Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight- or 12-hour intervals.

SUPPLIED: In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity.
Be sure your hospital has it stocked.

Abbott

1. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
2. Antibiotics Annual, 1957-58, p. 187-98.
3. J.A.M.A., 167:1584, July 26, 1958.



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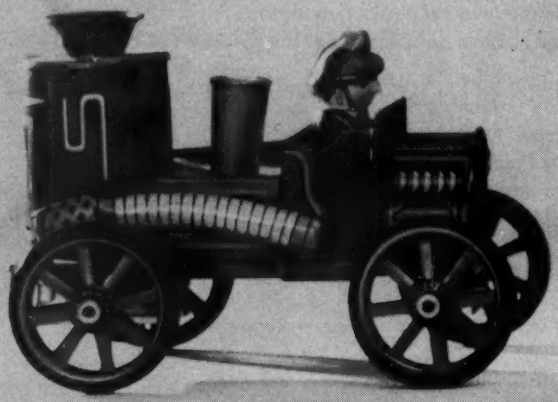

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inflammatory-suppressive . . .
potent, prompt, sustained action with prednisolone

inflammatory-corrective . . .
reduction of abnormal capillary permeability with citrus bioflavonoids

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with citrus bioflavonoids . . .
against ecchymoses, purpuras, gastric hemorrhage and other steroid-induced capillary damage

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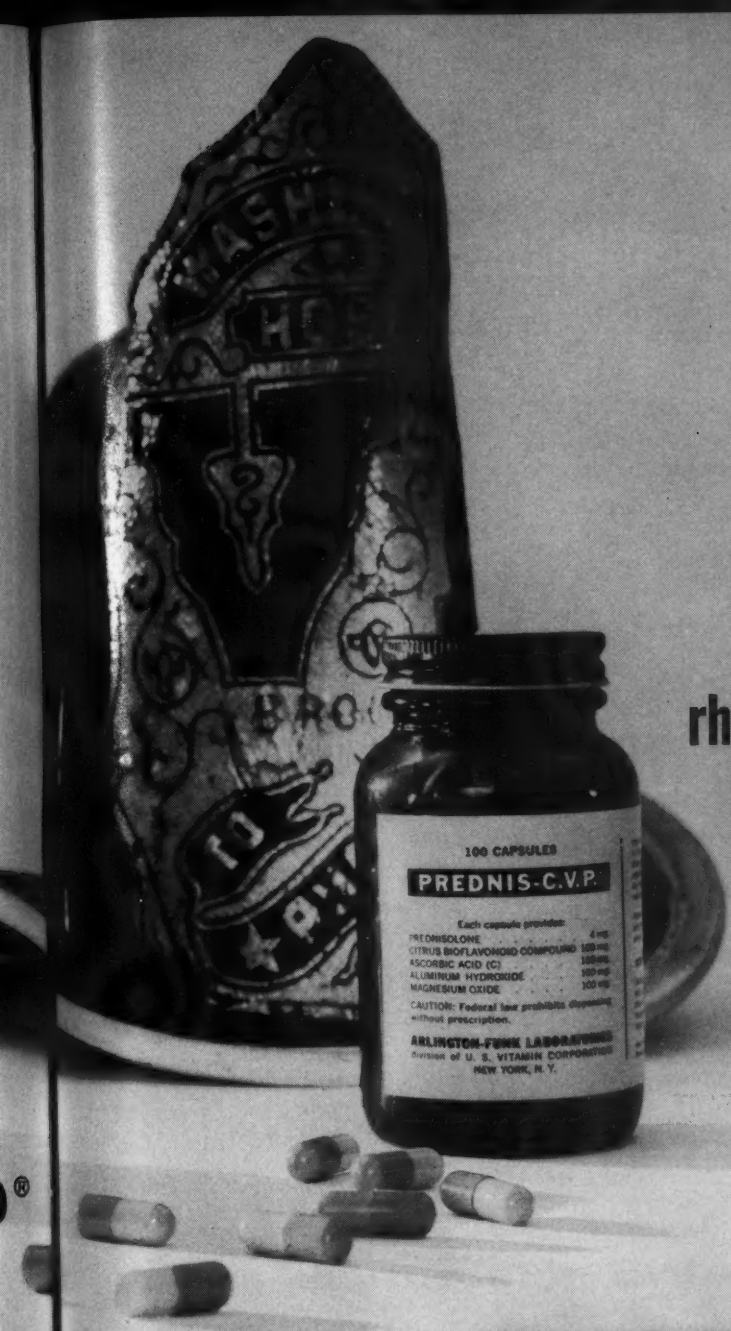

in rheumatoid arthritis bronchial asthma eczemas

and other inflammatory, allergic and rheumatic conditions

suggested dosage:

Average initial dose, 2 to 5 capsules daily, in divided doses; in severe cases, 6 to 10 capsules daily. Gradually reduce dosage to effective maintenance level.

Bottles of 30, 100 and 500 capsules.

Each **PREDNIS-C.V.P.** capsule provides:	
PREDNISOLONE	4 mg
CITRUS BIOFLAVONOID COMPOUND	100 mg
ASCORBIC ACID (C)	100 mg
ALUMINUM HYDROXIDE	100 mg
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The great corticosteroid era
opened ten years ago
with the introduction of CORTONE® (cortisone).
Today, MERCK SHARP & DOHME proudly
presents the crowning
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decade—DECADRON (dexamethasone)
—a new and unique compound, which
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DEXAMETHASONE

to treat more patients more effectively

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In Anti-Inflammatory Potency

DECADRON "possesses greater anti-inflammatory potency per milligram than any steroid yet produced,"[1] and is "the most potent steroid thus far synthesized."[2] Milligram for milligram, it is, on the average, 5 times more potent than 6-methylprednisolone or triamcinolone; 7 times more potent than prednisone; 28 times more potent than hydrocortisone; and 35 times more potent than cortisone.

In Dosage Reduction

Thanks to this unprecedented potency, DECADRON is "highly effective in suppressing the manifestations of rheumatoid arthritis when administered in remarkably small daily milligram doses."[3] In a number of cases, doses as low as 0.5-0.8 mg. proved sufficient for daily maintenance. The average maintenance dosage in rheumatoid arthritis is about 1.5 mg. daily.

In Elimination and Reduction of Side Effects

Virtual absence of diabetogenic activity, edema, sodium or water retention, hypertension, or psychic reactions has been noted with DECADRON.[1,2,3,4] Other "classical" reactions were less frequent and less severe. DECADRON showed no increase in ulcerogenic potential, and digestive complaints were rare. Nor have there been any new or "peculiar" side effects, such as muscle wasting, leg cramps, weakness, depression, anorexia, weight loss, headache, dizziness, tachycardia or erythema. Thus DECADRON introduces a new order of magnitude in safety, unprecedented in corticosteroid therapy.

In Therapeutic Effectiveness

With DECADRON, investigators note "a decided intensification of the anti-inflammatory activity"[3] and antirheumatic potency.[4] Clinically, this was manifested by a higher degree of improvement in many patients, previously treated with prednisteroids,[3] and by achievement of satisfactory control in an impressive number of recalcitrant cases.[3,4]

In Therapeutic Range

More patients can be treated more effectively with DECADRON. Its higher anti-inflammatory potency frequently brings relief to cases resistant to other steroids. Virtual freedom from diabetogenic effect in therapeutic dosage permits treatment of many diabetics without an increase in insulin requirements. Absence of hypertension and of sodium and fluid retention allows effective therapy of many patients with cardiovascular disorders. Reduction in the incidence and severity of many side effects extends the benefits of therapy to numerous patients who could not tolerate other steroids. And a healthy sense of well-being, reported by nearly all patients on DECADRON, assures greater patient cooperation.

References:

1. Boland, E.W.: California Med. 88:417 (June) 1958.
2. Bunim, J.J., et al.: Arthr. & Rheum. 1:313 (Aug.) 1958.
3. Boland, E.W., and Headley, N.E.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.
4. Bunim, J.J., et al.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.

To treat more patients more effectively in all allergic and inflammatory disorders amenable to corticosteroid therapy

DOSAGE AND ADMINISTRATION

With proper adjustment of dosage, treatment may ordinarily be changed over to DECADRON from any other corticosteroid on the basis of the following milligram equivalence:

One 0.75 mg. tablet of DECADRON (dexamethasone) replaces:

↓ One 4 mg.	↓ One 5 mg.	↓ One 20 mg.	↓ One 25 mg.
tablet of methylprednisolone or triamcinolone	tablet of prednisolone or prednisone	tablet of hydrocortisone	tablet of cortisone

SUPPLIED:

As 0.75 mg. scored pentagon-shaped tablets; also as 0.5 mg. tablets to provide maximal individualized flexibility of dosage adjustment.

Detailed literature is available to physicians on request.

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opened ten years ago
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Today, MERCK SHARP & DOHME proudly
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—a new and unique compound, which
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to treat more patients more effectively

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for Rauwiloid IS better tolerated... "alseroxylon [Rauwiloid] is an antihypertensive agent of equal therapeutic efficacy to reserpine in the treatment of hypertension but with significantly less toxicity."

*Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension, Postgrad. Med. 23:41 (Jan.) 1958.

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ALSEROXYLON, 2 MG.

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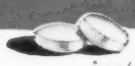

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Trisulfaminic *tablets and suspension*

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Each Tablet and each 5 ml. teaspoonful of Suspension contains:

Triaminic®	25 mg.
(phenylpropanolamine HCl	12.5 mg.;
pheniramine maleate	6.25 mg.;
pyrilamine maleate	6.25 mg.)
Trisulfapyrimidines U.S.P.	0.5 Gm.

Dosage: Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.

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In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

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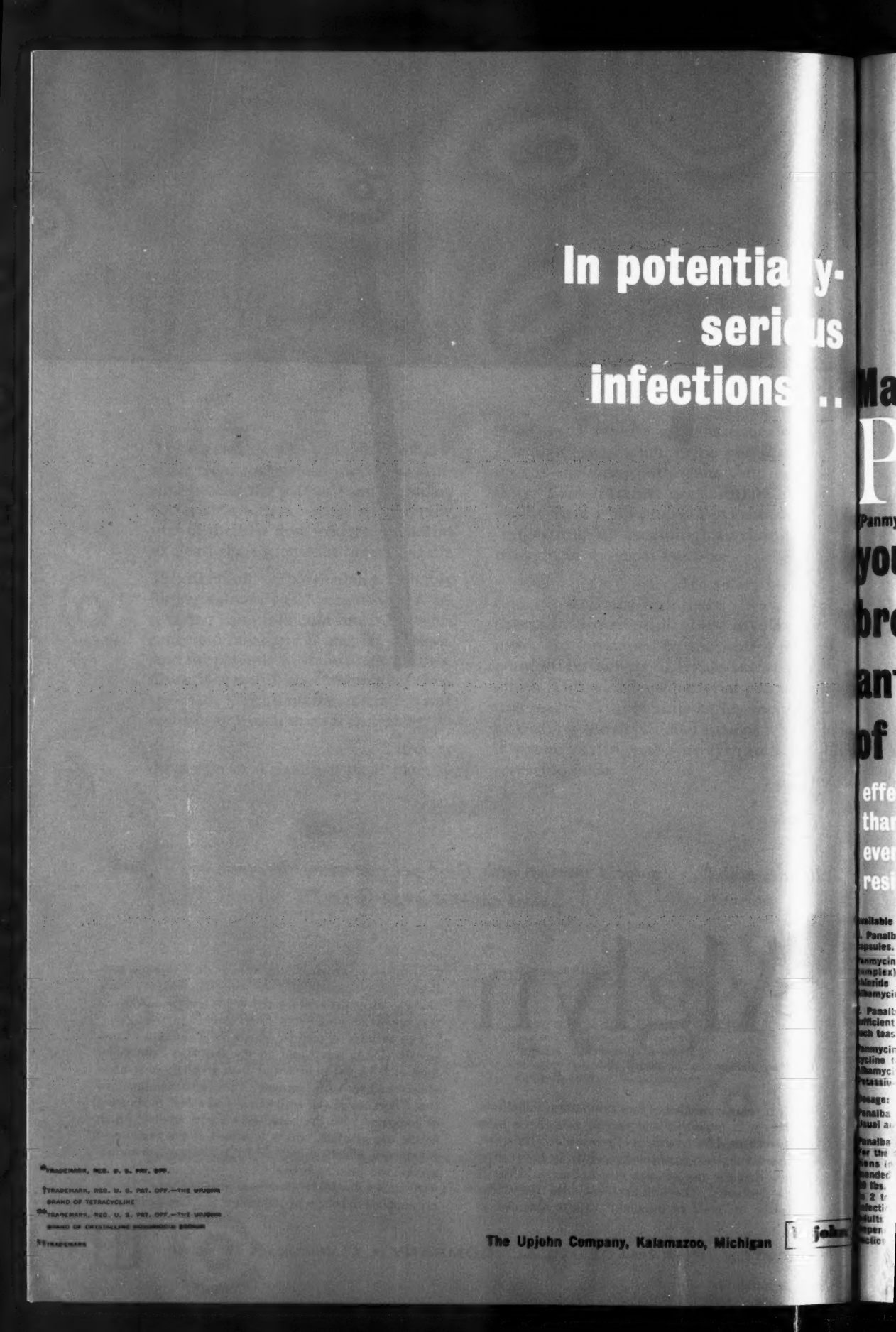


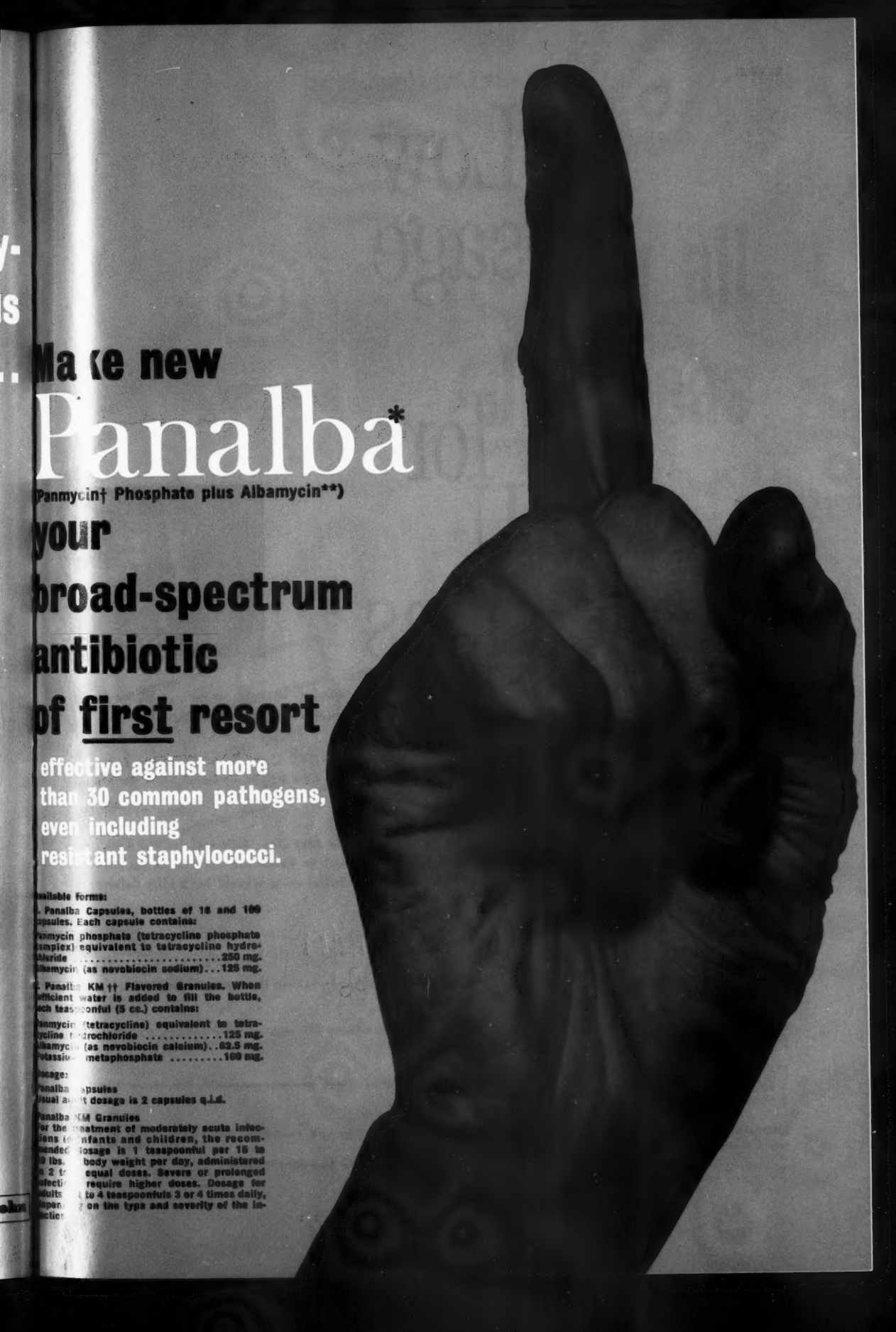
*TRADEMARK, REG. U. S. PAT. OFF.

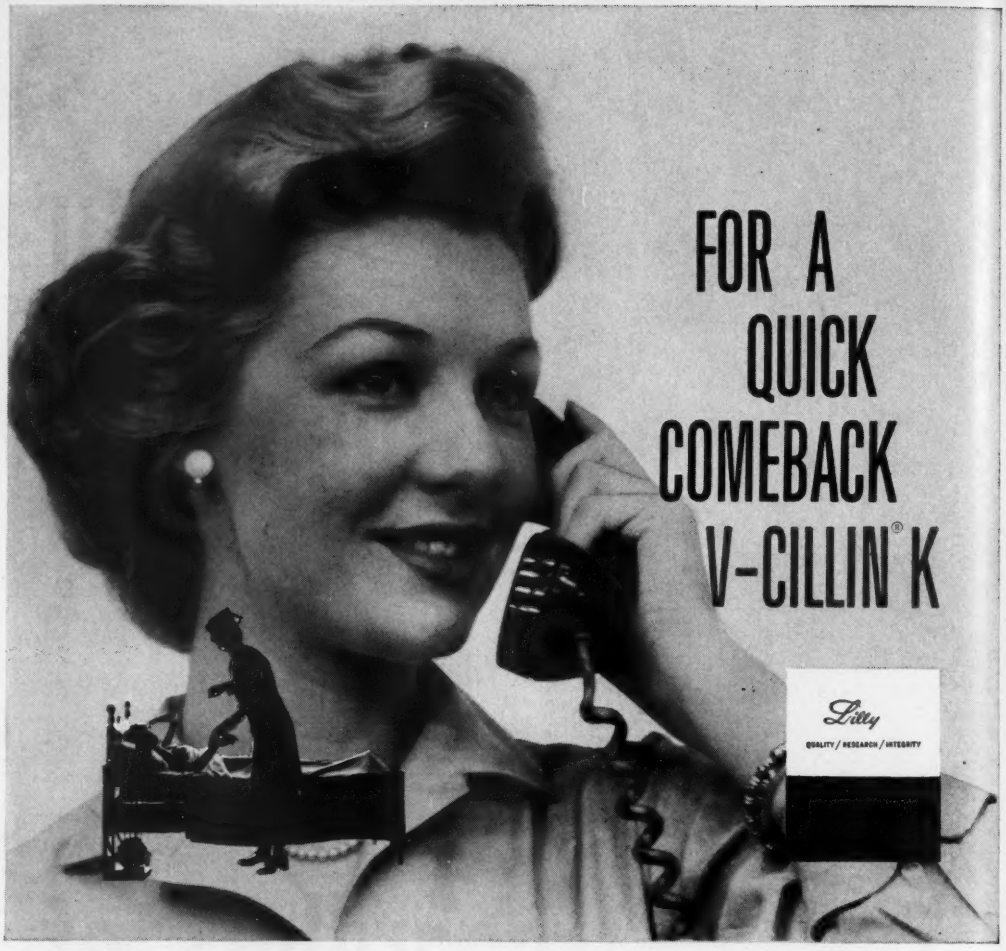
†TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF TETRACYCLINE

‡‡TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF CHLORTETRACYCLINE HYDROCHLORIDE

§§TRADEMARK

The Upjohn Company, Kalamazoo, Michigan


Make new
Panalba*
(Panmycin† Phosphate plus Albamycin**)
your
broad-spectrum
antibiotic
of first resort
effective against more
than 30 common pathogens,
even including
resistant staphylococci.
Available forms:
1. Panalba Capsules, bottles of 16 and 100
capsules. Each capsule contains:
Panmycin phosphate (tetracycline phosphate
complex) equivalent to tetracycline hydro-
chloride .....250 mg.
Albamycin (as novobiocin sodium)...125 mg.
2. Panalba KM †† Flavored Granules. When
sufficient water is added to fill the bottle,
each teaspoonful (5 cc.) contains:
Panmycin (tetracycline) equivalent to tetra-
cycline hydrochloride .....125 mg.
Albamycin (as novobiocin calcium)..62.5 mg.
Potassium metaphosphate .....100 mg.
Dosage:
Panalba Capsules
Usual adult dosage is 2 capsules q.i.d.
Panalba KM Granules
For the treatment of moderately acute infec-
tions in infants and children, the recom-
mended dosage is 1 teaspoonful per 15 to
30 lbs. body weight per day, administered
in 2 to 4 equal doses. Severe or prolonged
infections require higher doses. Dosage for
adults 2 to 4 teaspoonfuls 3 or 4 times daily,
depending on the type and severity of the in-
fection



provides dependable, fast, effective therapy

dependable action

because all patients show therapeutic blood concentrations of penicillin with recommended dosages.

quick deployment

of the bacteria-destroying antibiotic. Within five to fifteen minutes after administration, therapeutic concentrations appear in the general circulation.

higher blood levels

than with any other penicillin given orally. Bactericidal concentrations are assured. Infections resolve rapidly.

Dosage: 125 or 250 mg. three times daily.

Supplied: Tablets, scored, of 125 and 250 mg. (200,000 and 400,000 units).

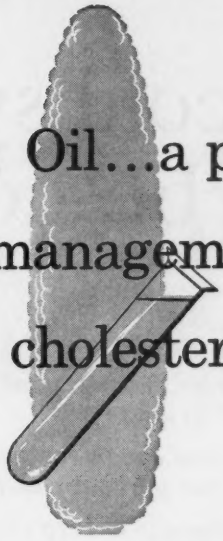
New V-Cillin K, Pediatric: In bottles of 40 and 80 cc. Each 5-cc. teaspoonful provides 125 mg. V-Cillin K.

V-Cillin® K (penicillin V potassium, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

833283

Mazola® Corn Oil...a palatable food effective in the management and control of serum cholesterol levels



Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal... high blood cholesterol levels are lowered, normal levels maintained.

Fortunately for both physician and patient, Mazola Corn Oil is not only rich in unsaturated fatty acids, it is also a delicious food. It becomes an enjoyable and normal part of the patient's daily meals—no complicated or special diet is required.

Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

IN COOKING OR SALADS

Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

MOST EFFECTIVE

Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

ECONOMICAL

Mazola Corn Oil is sold in grocery stores throughout the country, is available everywhere. Its comparatively low cost makes it as economical as it is effective.

MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

Linoleic Acid	7.4 Gm.
Sitosterols	130 mg.
Natural Tocopherols	15 mg.

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

*Reg. U. S. Pat. Off.

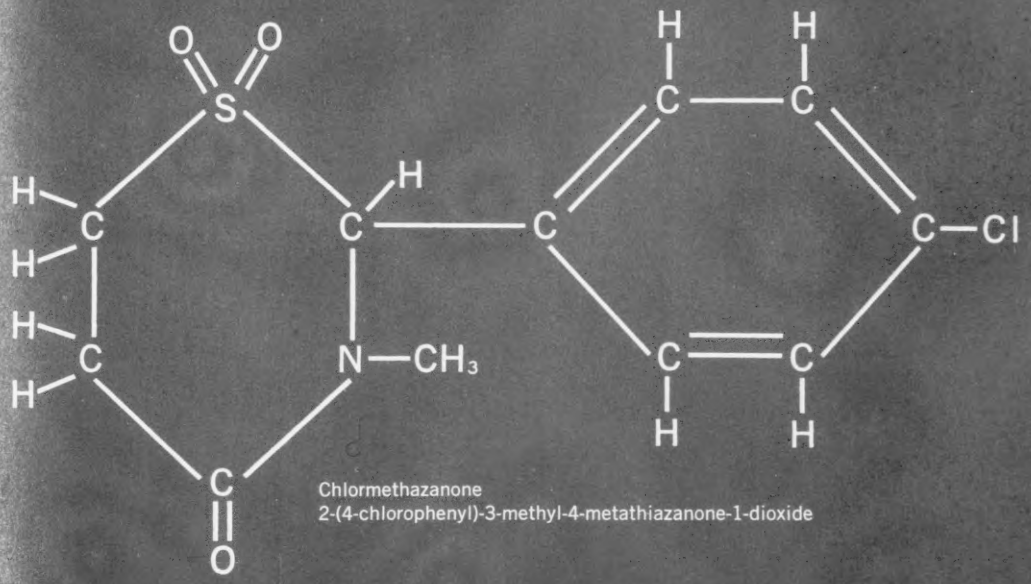
CORN PRODUCTS REFINING COMPANY

Winthrop Laboratories
introduces

Trancopal®

BRAND OF CHLORMETHAZANONE

a completely new major chemical contribution to therapeutics



Chlormethazanone
2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

unrelated chemically to any other drug in current use

designed to be equally effective as both

a MUSCLE RELAXANT

a TRANQUILIZER

Trancopal

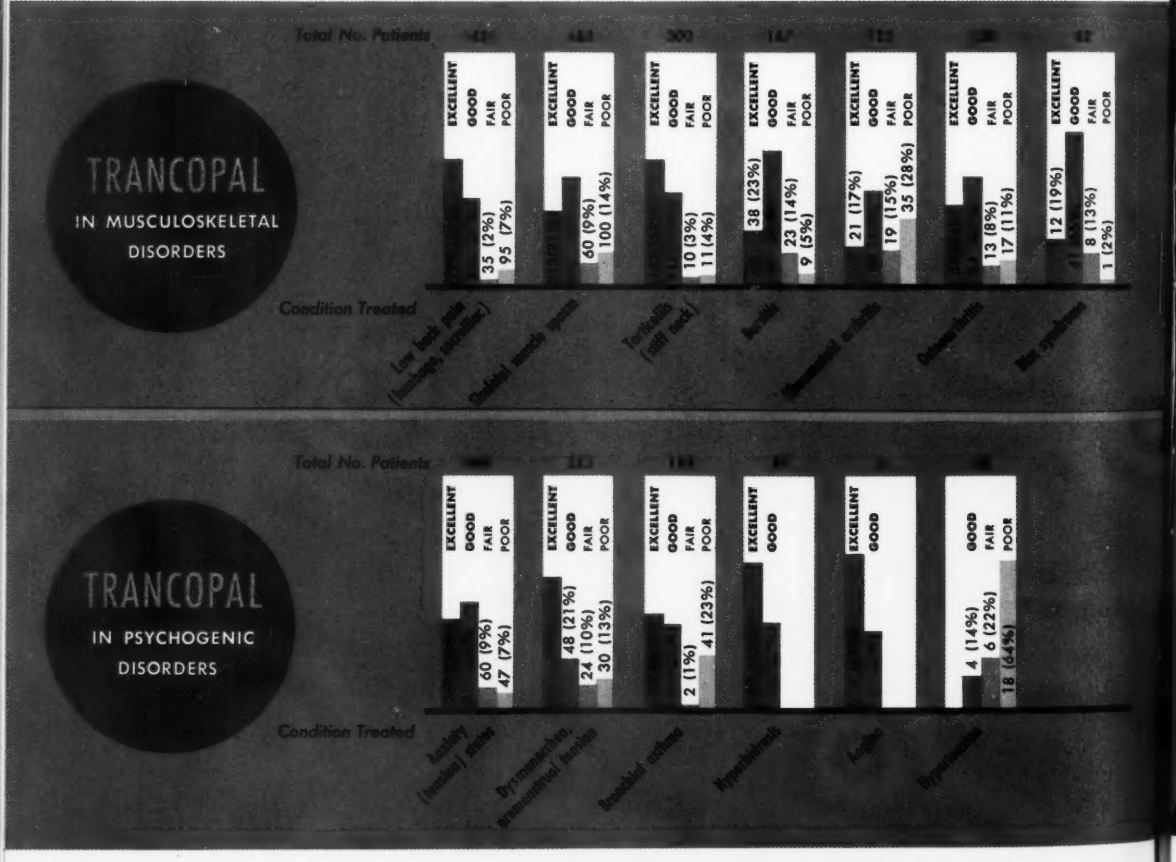
*the first true "TRANQUILAXANT"**

offering new freedom for your patients... from muscle spasm, from tension and anxiety, from side effects

* **tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]

EXCEEDS OLDER DRUGS UP TO 4 TIMES IN PERCENTAGE OF CLINICAL EFFICACY (Lichtman)

The results of clinical studies of over 4000 patients by 105 physicians demonstrate that TRANCOPAL often is effective when other drugs have failed. From these studies it is clear that TRANCOPAL probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other chemotherapeutic agent in current use.



TRANCOPAL... the first true "tranquilaxant"

Both a muscle relaxant and a calmative agent.

In musculoskeletal disorders, 91 per cent effective.

In anxiety and tension states, 93 per cent effective.

Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.

No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.

Low toxicity. In animals, even less toxic than aspirin.

No gastric irritation. Can be taken before meals.

No clouding of consciousness, no euphoria or depression.

No perceptible soporific effect, even in high dosage.

CLINICAL RESULTS IN 4092 PATIENTS

MUSCULOSKELETAL CONDITIONS
2929 Patients

+

PSYCHOGENIC CONDITIONS
1163 Patients

=

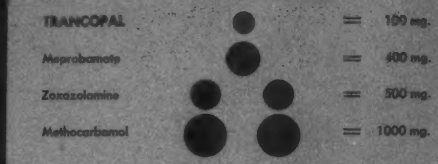
TOTAL 4092 Patients

MAJOR IMPROVEMENT
84%

Compare Trancopal with 3 widely used central relaxants

FOR ACTIVITY

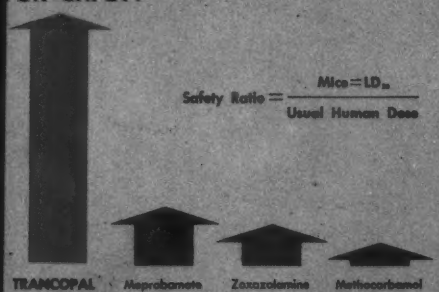
Single Dose



Daily Dose
Same as above, t.i.d.

Considering the usual human dose, Trancopal, the first true "tranquilaxant," is four to ten times as potent per milligram.

FOR SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.

FOR CLINICAL EFFECTIVENESS

A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of 40 patients received all four drugs in random rotation for several days. While each of the four drugs gave some relief, only the one providing the most effective relief was recorded.

INDICATIONS

Musculoskeletal
- Low back pain (lumbago)
- Neck pain (torticollis)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disc syndrome
- Fibrositis
- Joint disorders (ankle sprain, tennis elbow, etc.)
- Myositis
- Postoperative myalgias

Psychogenic
- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Emphysema
- Angina

Neurologic
- Muscle spasm in paralysis agitans, multiple sclerosis, hemiplegia, poliomyelitis

TRANCOPAL thoroughly evaluated clinically

"In the treatment of conditions associated with skeletal muscle spasm there was a high percentage of satisfactory results (excellent, good or fair) in 310 patients (94%) out of 331 treated. . . . In 120 patients with simple anxiety or tension states results were satisfactory in 114 (95%). Dosage of chlormethazanone in all cases was 100 mg. t.i.d. As well as relieving the anxiety or tension state, chlormethazanone also allowed these patients to resume their usual occupations." (Lichtman)

Trancopal

the first true "TRANQUILAXANT"

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

Winthrop Laboratories • New York 18, N. Y.

• Baker, A. B.: Modern Med. 26:140, April 15, 1958. • Cohen, A. I.: In preparation. • Cooperative Study, Department of Medical Research, Winthrop Laboratories. • Gesler, R. M., and Coulston, F.: Toxicol. & Appl. Pharmacol. To be published. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:24A, Jan., 1958. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:517, April, 1958. • Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. • Surrey, A. R.; Webb, W. G., and Gesler, R. M.: J. Am. Chem. Soc. 80:3469, July 5, 1958.

Printed in U. S. A. 11-58 (3920)

you were to examine these patients

could you detect the asthmatic on Medrol*?

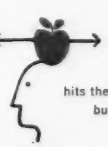
Probably not. Not without a history.

First, because he's more than likely symptom-free.

Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?



Medrol hits the **disease,** but spares the **patient**

*TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN

ohn

ohn Company, Kalamazoo, Michigan

"Much better–thank you, doctor"

Proven in research

1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
3. Safe, physiologic potentiation (with a natural human metabolite)

And now in practice

4. More rapid clinical response
5. Unexcelled toleration

COSA-TETRACYN*

GLUCOSAMINE-POTENTIATED TETRACYCLINE

CAPSULES
(black and white)
250 mg., 125 mg.
(for pediatric or long-term therapy)

ORAL SUSPENSION
(orange-flavored)
125 mg. per tsp. (5 cc.)
2 oz. bottle

NEW! PEDIATRIC DROPS
(orange-flavored) 5 mg. per drop, calibrated dropper,
10 cc. bottle

COSA-TETRASTATIN*

glucosamine-potentiated tetracycline with nystatin

Antibacterial plus added protection against monilial super-infection

CAPSULES (black and pink) 250 mg. Cosa-Tetracyn (with 250,000 u. nystatin)

ORAL SUSPENSION 125 mg. per tsp. (5 cc.) Cosa-Tetracyn (with 125,000 u. nystatin), 2 oz. bottle

COSA-TETRACYDIN*

glucosamine-potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

CAPSULES (black and orange)—each capsule contains: Cosa-Tetracyn 125 mg.; phenacetin 120 mg.; caffeine 30 mg.; salicylamide 150 mg.; buclizine HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Antibiotic Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and leukemia, Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Antibiotic Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Antibiotic Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

Pfizer *Science for the world's well-being* *Trademark

PFIZER LABORATORIES *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York*

When writing to advertisers please mention the Journal—it helps

PREVENT both cause and fear of ANGINA ATTACKS

proven safety for long-term use

Miltrate*

NEW DOVETAILED THERAPY COMBINES IN ONE TABLET

prolonged relief from anxiety and tension with **MILTOWN®** — The *original* meprobamate, discovered and introduced by Wallace Laboratories

+

sustained coronary vasodilation with **PETN** — pentaerythritol tetranitrate a leading, long-acting nitrate

"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 47C

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

Exactly <u>how</u> does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

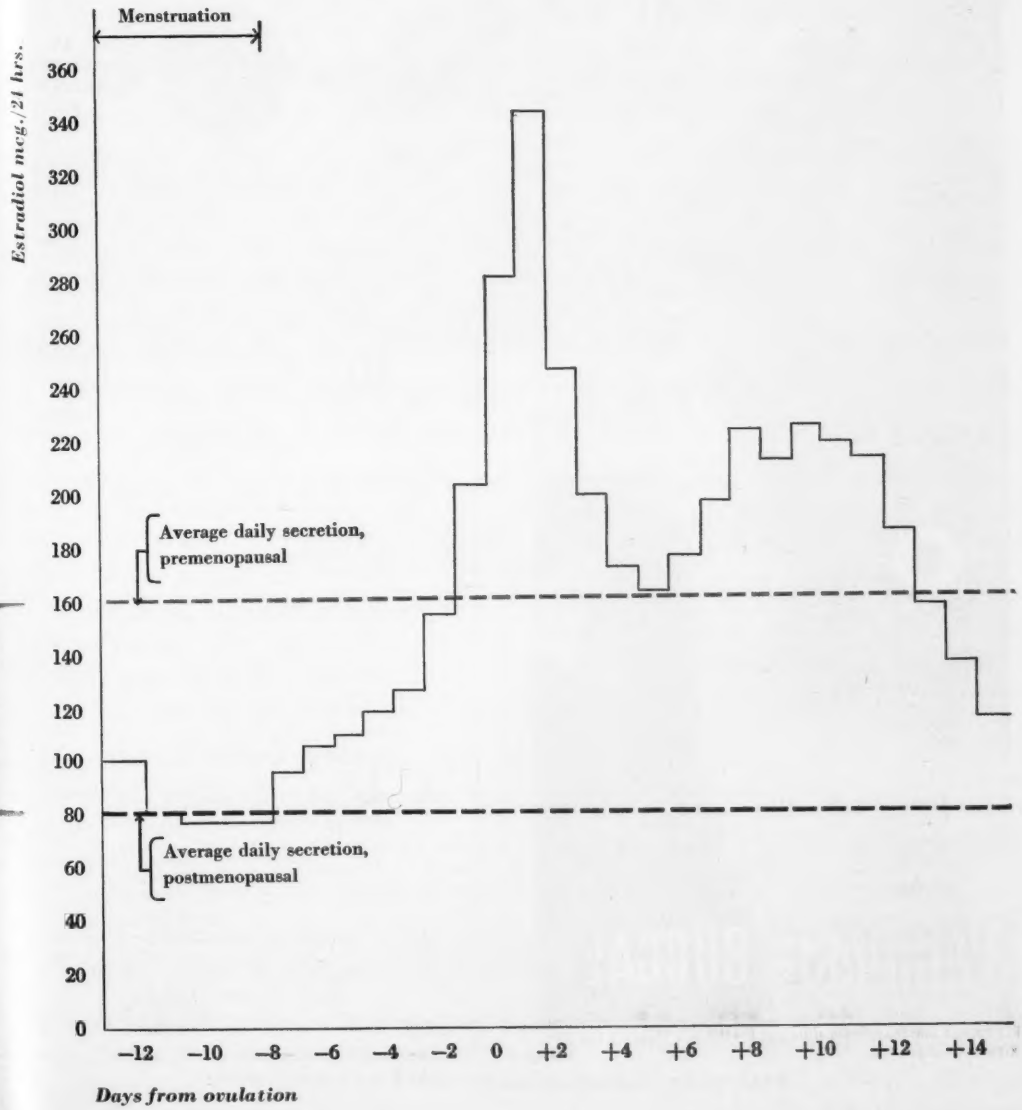
Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion of estradiol, estrone, and estriol)



INDEX TO ADVERTISERS

*Compazine**

nausea and vomiting

—from virtually any cause

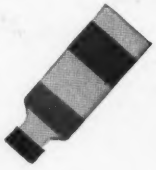
- in pregnancy—pre- and postoperative states—gastroenteritis—alcoholism—cancer and chronic diseases
- control is achieved with low dosage—usually 15 to 20 mg. daily—and often within a half hour after the first oral dose

'Compazine' is remarkable for its freedom from drowsiness. Patients carry on normal activities and often experience an actual alerting effect.

...for immediate control of severe vomiting:

Ampuls, 2 cc. (5 mg./cc.)

NEW: Multiple dose vials, 10 cc. (5 mg./cc.)



—always carry one in your bag

Also available:

Tablets, 5, 10 and 25 mg., in bottles of 50 and 500.
Spansule†capsules, 10, 15 and 30 mg., in bottles of 30 and 250.
Suppositories, 5 and 25 mg., in boxes of 6.
Syrup, 5 mg./teaspoonful (5 cc.), in 4 fl. oz. lightproof bottles.

Smith Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for prochlorperazine, S.K.F.
†T.M. Reg. U.S. Pat. Off. for sustained release capsules, S.K.F.

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